

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3392

## CERTIFICATE OF DEATH

Reg. Dist. No.

03381

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Fox St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLIVE Jane Aldrich</u>				4. DATE OF DEATH Month Day Year <u>March 10 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(none)</u>		11. BIRTHPLACE (State or foreign country) <u>Pike Co. Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>George Hall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Edington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Olive Hertko</u>		Address <u>1917 Fox St Hyattsville, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u> <u>10-12 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe, Generalized Rheumatoid Arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Feb. 1958</u> , to <u>Mar. 10, 1961</u> , that I last saw the deceased alive on <u>Mar. 8, 1961</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u>				ADDRESS (Street, city or town, state) <u>M.D. 1806 Fox St. Hyattsville, Maryland</u>		DATE SIGNED <u>3/10/61</u>	
PHYSICIAN'S NAME (Type) <u>James L. Laubach</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. * Washington D.C.</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3393  
CERTIFICATE OF DEATH

Reg. Dist. No. 03382

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Mt. Rainier,		d. STREET ADDRESS 3212 Chillum Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Belle Middle H. Last Alexander		4. DATE OF DEATH Month March Day 13, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/89
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Mineral Wells, Tex.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Crawford Haynes		14. MOTHER'S MAIDEN NAME Virginia Katherine Hyman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address John A. Alexander, son above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Infarction, left cerebrum DUE TO thrombosis left mid cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertensive arteriosclerotic vascular renal disease (c) 6 mos.		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 19 61, to March 13, 19 61, that I last saw the deceased alive on March 13, 19 61, and that death occurred at 8:10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4637 Eastern Avenue	
PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M. D.		Washington 18, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/61	22c. NAME OF CEMETERY OR CREMATORY Elmwood	22d. LOCATION (City, town, or county) (State) Mineral Wells, Texas
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR ADDRESS Mt. Rainier, Md. DATE MAR 17 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1911

1911

John Doe, of the County of \_\_\_\_\_ State of Michigan, died on the \_\_\_\_\_ day of \_\_\_\_\_ 1911, at \_\_\_\_\_ Michigan, of \_\_\_\_\_

The cause of death was \_\_\_\_\_

The attending physician is \_\_\_\_\_

The death was reported to the health officer by \_\_\_\_\_

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_ 1911.

FILED  
MAY 10 1911  
MICHIGAN  
DEPARTMENT OF HEALTH



3394  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASHINGTON 23, D.C.</b> <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS AFB, WASH 25, DC.</b>		d. STREET ADDRESS <b>37 PICKETT DR S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BRUCE</b> Middle <b>EDWARD</b> Last <b>ALLBRIGHT</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 FEBRUARY 1961</b>
9. AGE (In years lost birthday) <b>12 days</b>		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JAMES E ALLBRIGHT</b>		14. MOTHER'S MAIDEN NAME <b>TRAVIS, RUTH ANNE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	
17. INFORMANT <b>NONE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE - ATRESIA OF AORTIC VALVE, HYPOPLASTIC LEFT VENTRICLE</b> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>CONGESTIVE HEART FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b> <b>36 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>28 FEB</b> 1961, to <b>12 MARCH</b> 1961, that (I) <del>the</del> last saw the deceased alive on <b>11 MARCH</b> 1961, and that death occurred at <b>3:30 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>ROBERT C BURKHART</b>		22b. DATE SIGNED <b>12 MAR 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C BURKHART CAPT USAF MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS AFB WASH. 25 D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>MARCH 13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eden Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Switzland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Samson Bros</b>		25a. REC'D BY REGISTRAR <b>1661-good Hope Rd</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		DATE <b>MAR 14 '61</b>	

2050362 XV3

hard-se

CERTIFICATE OF DEATH

3386

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

SIGNATURE OF REGISTRAR: [illegible]  
DATE: [illegible]  
PLACE: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		Prince George's		a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		District Heights		b. COUNTY		Prince George's	
c. LENGTH OF STAY IN 1b		Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
District Heights Medical Center				Box 1299, Upper Marlboro, Md.			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Wade Henry Armstrong				March 23, 1961			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 23, 1910	50 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Mechanic		Automobile		Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Clifford Armstrong				Frances Marshall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes		WW II 578-09-3026		Mrs Alva E. Armstrong, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
420.1 DUE TO Acute congestive heart failure							
Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerotic heart disease							
(a), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Diabetes							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
Hour a.m. p.m.		19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3/23/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		Mar 27-61		Washington Natl.		Suitland Md	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Simmons Bros.		1061-Good Hope Rd SE WASH. DC.		MAR 27 '61		C. S. F. H. H.	

# MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3395 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03384

(M)

(I)

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3396											
03385											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b. 6 months and 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS 2891 Hartford St., S. E.						
3. NAME OF DECEASED (Type or print) First Middle Last William C. Atkins					4. DATE OF DEATH Month Day Year 3 8 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/1890		9. AGE (In years last birthday) 70 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer					10b. KIND OF BUSINESS OR INDUSTRY Self-employed Retired farmer		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Atkins					14. MOTHER'S MAIDEN NAME Lucy Pace						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis, far advanced; diabetes mellitus; thyroid adenoma									INTERVAL BETWEEN ONSET AND DEATH 2 yrs., 4 mo.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 8/12/1960, to 3/8/1961, that (I) (we) last saw the deceased alive on 3/8/1961, and that death occurred at P.M., from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/8/1961				
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-61		23c. NAME OF CEMETERY OR CREMATORY Wash national			23d. LOCATION (City, town or county) (State) Sutland Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Chambers Co					ADDRESS 1400 Cham St NW		25a. REGISTERED BY DATE MAR 13 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Hays		

3336

11382

(1)

(1)

Prothrombin time

Polymyositis, interstitial, for advanced: diabetes mellitus, thyroid adenoma

Miss Brown

Chlorine 1000 mg. daily  
Sodium 3000 mg. daily



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3397

## CERTIFICATE OF DEATH

03386

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>8 hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>				d. STREET ADDRESS <b>4117 70th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Carol Ann</b> Middle <b>-</b> Last <b>Baker</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-31-60</b>	
9. AGE (In years last birthday) <b>11 weeks</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>JOHN R. BAKER</b>				14. MOTHER'S MAIDEN NAME <b>MARY J. KLEIN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN R. BAKER</b> Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, interstitial, bilateral</b> 525X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>-</b> e.m. <b>-</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> , 19 <b>60</b> , to <b>3/20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>61</b> , and that death occurred <b>8:15 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frederick E. Musser M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>F. E. Musser</b>				22d. ADDRESS <b>4410 74<sup>th</sup> Lane Landover Hills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-23-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION (City, town or county) (State) <b>WHEATON, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Riverdale</b>				25a. REC'D BY REGISTRAR <b>MAR 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

2077283XV4

M

1937

COMMERCIAL NORTH

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Princeton, N.J.

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1 hour

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Princeton, N.J.

Princeton, N.J.

John R. BAKER

John R. BAKER

NO

John R. BAKER

Princeton, N.J.

Princeton, N.J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

(M)

(I)

3398

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03307

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>15 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lanham</b> d. STREET ADDRESS <b>1 7310 Lois Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Bakken</b> Last <b>Bakken</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1961</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-72</b>	9. AGE (In years lost birthday) <b>89 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rancher</b>	11. BIRTHPLACE (State or foreign country) <b>Ilesorah, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Lars Bakken</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Daughter</b> <b>Mrs. Kirsten Masseranon</b> Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 3322X DUE TO Cerebral arteriosclerosis Condillons, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs.</b> <b>5 yrs</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. . p. m. . 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 55</b> to <b>24 Mar 1961</b> that (I) (we) last saw the deceased alive on <b>4 Mar 1961</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>John Kehoe</b> M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/25/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Kehoe</b>		22d. ADDRESS <b>6350 Riverdale Rd</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home</b> <b>Inc.</b>		ADDRESS <b>mt. Rainier</b> <b>md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Jones</b>			

STATEMENT OF DEATH

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>LANDOVER</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLUMBIA PARK</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ANTONIO A. BARNACLO</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 29 1961</u>							
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-18-87</u>		<b>9. AGE</b> (In years lost birthday) <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Maintenance man</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>W. S. S. C.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D. C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>James K. Barnaclo</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Crowley</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <u>WW1</u>				<b>16. SOCIAL SECURITY NO.</b> <u>215 38 3130</u>		<b>17. INFORMANT</b> Address <u>Minnie E Barnaclo E Columbia Park, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>153.0</u> DUE TO <u>Adenocarcinoma of Ascending Colon</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-15</u> <u>1961</u> , <b>to</b> <u>3-29</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3-29</u> <u>1961</u> , <b>and that death occurred at</b> <u>10:30</u> <u>AM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Dr. A. Deitz</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/29/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. A. Deitz</u>						<b>22d. ADDRESS</b> <u>Hyattsville, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/31/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Arlington National</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Arlington Virginia</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons Hyattsville, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 3 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. L. Knaus</u>			

03388

3389

CERTIFICATE OF DEATH

Name of Deceased: Prince George  
 Date of Birth: [illegible]  
 Date of Death: [illegible]  
 Place of Birth: [illegible]  
 Cause of Death: [illegible]  
 Signature of Doctor: [illegible]  
 Signature of Registrar: [illegible]

Registered at [illegible] on [illegible]  
 Signature of Registrar: [illegible]  
 Signature of Medical Officer: [illegible]

[Faint, mostly illegible text and signatures in the lower half of the page, including what appears to be a signature of Dr. A. B. [illegible] and other official markings.]



1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03389

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>		c. LENGTH OF STAY IN TB <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		d. STREET ADDRESS <b>4663 Kenderick Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5605 Marlboro Pike S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Norris</b>		First Middle Last <b>Bartlett</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 61.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1910</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchandising</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oscar Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Callie Morgan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>Mrs Kathleen Bartlett, same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 19, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>W.W. Chambers Company 517 11th st. S.E.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 21 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

Wash. D.C.

4036

3400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MISSISSIPPI  
COUNTY OF PRINCE GEORGE

Princo George County Mississippi

Millard

300 Lexington Place N.E.

Atlanta Georgia

June 11, 1930

U. S. A.

Once Excluded

1st National Bank, same day

with negative result

Cardinal's seal

Cardinal's seal

Cardinal's seal

Cardinal's seal

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### 3401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03390

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>William Everett Blair</b>		<b>4. DATE OF DEATH</b> <b>March 14, 1961</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 1, 1945</b>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>		<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <b>SCHOOL</b>	
<b>10. FATHER'S NAME</b> <b>Merle S. Blair</b>		<b>11. MOTHER'S MAIDEN NAME</b> <b>Catherine F. Goddard</b>	
<b>12. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>13. SOCIAL SECURITY NO.</b> <b>Unknown</b>	
<b>14. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>812X</b> <b>Hemorrhage and shock</b>		<b>15. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1401 Boones Hill Rd. Coral Hills, Md.</b>	
<b>16. PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Compound fracture of the skull and facial bones</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>multiple fractures of the left femur and ankle</b>		<b>17. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Pedestrian struck by an automobile</b>	
<b>18a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>7:15 p.m. 3/14/61</b>		<b>18b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Spaulding heights P. G. Md.</b>	
<b>19a. TIME OF INJURY</b> Month, Day, Year <b>7:15 p.m. 3/14/61</b>		<b>19b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
<b>20a. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		<b>20b. (City or town)</b> <b>Spaulding heights P. G. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>22. ACTUAL SIGNATURE</b> <b>James I. Boyd</b>		<b>23. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>24. EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>		<b>25. DATE SIGNED</b> <b>3/14/61</b>	
<b>26a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>26b. DATE THEREOF</b> <b>3-18-1961</b>	
<b>27a. NAME OF CEMETERY OR CREMATORY</b> <b>National Mem. Park</b>		<b>27b. LOCATION</b> (City, town, or country) (State) <b>Halls Church, Virginia</b>	
<b>28. FUNERAL DIRECTOR</b> <b>W. W. CHAMBERS CO.,</b>		<b>29. ADDRESS</b> <b>Riverdale, Maryland.</b>	
<b>30a. REC'D BY REGISTRAR</b> <b>MAR 17 '61</b>		<b>30b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Turner</b>	

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Figure 1. The study area.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3402

CERTIFICATE OF DEATH

Reg. Dist. No.

03391

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Clinton Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At 1 - Box 570 Clinton</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>3. H.</u> Middle <u>D.</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>3</u> - Day <u>19</u> - Year <u>1961</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14-1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Thompson</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thom Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Sproule</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr. James Bradley</u> Address <u>Clinton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis &amp; Senility</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>March 19</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 18</u> , 19 <u>61</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P D'Angelo M.D.</u>				ADDRESS (Street, city or town, state) <u>4223 Silver Hill Rd Wash DC.</u>			
PHYSICIAN'S NAME (Type) <u>John P D'Angelo M.D.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West End</u>		22d. LOCATION (City, town, or county) (State) <u>Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wash Fun Home</u>				ADDRESS <u>741-11th St. W.P.E. &amp; C</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>			

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## CERTIFICATE OF DEATH

Reg. Dist. No.

03392

3403

1. PLACE OF DEATH COUNTY <u>Prince George's Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood</u>				c. LENGTH OF STAY IN 1b <u>lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				d. STREET ADDRESS <u>Westwood</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Francis Butler</u>				4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-1903</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ryan Butler</u>				14. MOTHER'S MARDEN NAME <u>Martha Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Clara Thomas - 310-11th St. S.E.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Acute Urinary Supp.</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>weakness &amp; anorexia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 6</u> , 19 <u>61</u> , to <u>Mar 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Mar 12</u> , 19 <u>61</u> , and that death occurred at <u>ENT</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3/15/61</u> ACTUAL SIGNATURE <u>V. M. Seron</u> M.D. <u>Aguasca</u> PHYSICIAN'S NAME (Type) <u>V. M. SERON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		22d. LOCATION (City, town, or county) <u>Baden Prince Georges Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Nelson</u>				ADDRESS <u>Aguasca Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3403

(M)

DECEASED NAME LAST FIRST MIDDLE (Print or Write)		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS (Print or Write)		DATE OF BIRTH YEAR MONTH DAY (Print or Write)	
PLACE OF BIRTH (Print or Write)		PLACE OF DEATH (Print or Write)	
OCCUPATION (Print or Write)		CAUSE OF DEATH (Print or Write)	
MANNER OF DEATH (Print or Write)		MEDICAL HISTORY (Print or Write)	
PRESENT ILLNESS (Print or Write)		PREVIOUS ILLNESS (Print or Write)	
PHYSICIAN'S SIGNATURE (Print or Write)		MEDICAL EXAMINER'S SIGNATURE (Print or Write)	
DATE OF DEATH YEAR MONTH DAY (Print or Write)		TIME OF DEATH HOUR MINUTE (Print or Write)	
PLACE OF INTERMENT (Print or Write)		NAME OF FUNERAL HOME (Print or Write)	
SIGNATURE OF REGISTRAR (Print or Write)		SIGNATURE OF CLERK (Print or Write)	

## CERTIFICATE OF DEATH

Reg. Dist. No.

03393

3404

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 OXON HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7634-BARTO AVE</u>		d. STREET ADDRESS <u>15620 BOCK RD SE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND J. CAMPBELL</u>		4. DATE OF DEATH Month Day Year <u>MARCH 29 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 13-1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES J. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert J. Campbell</u>		Address <u>7634-BARTO AVE CAMP SPRINGS MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>61</u> , to <u>Mar. 29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>61</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Wisotsky</u> M.D.		ADDRESS (Street, city or town, state) <u>101 Ardley Lane SE</u> DATE SIGNED <u>3/29/61</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT WISOTSKY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 1-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Admiral Assoc.</u> ADDRESS <u>1661- Good Hope Rd SE WASH DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3405

CERTIFICATE OF DEATH

03394

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>71 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lehigh Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last		4. DATE OF DEATH <u>March 26</u> 19 <u>61</u> Year Month Day	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8 - 1897</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>City of Hyattsville Md</u>	
12. BIRTHPLACE (State or foreign country) <u>Italy</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>John Carboni</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>579 05 8358</u>	
18. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>578X Gastrointestinal tract hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>undiagnosed disease of GI tract</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-5</u> 19 <u>61</u> , to <u>3-26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-25</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>D R Purdie</u>		22b. DATE <u>March 26, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>D R Purdie</u>		22d. ADDRESS <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/29/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 29 '61</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	







may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3406

CERTIFICATE OF DEATH

Reg. Dist. No. 03395

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>				c. LENGTH OF STAY IN 1b <b>60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3111 Lancer Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Caruso</b> Last <b>Caruso</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1892</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>mos</b> Hours <b>+</b> Min.		11. IF UNDER 24 HRS. Months <b>8</b> Days <b>mos</b> Hours <b>+</b> Min.		12. IF UNDER 24 HRS. Months <b>8</b> Days <b>mos</b> Hours <b>+</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Produce Merchant</b>			
11. BIRTHPLACE (State or foreign country) <b>Italy</b>				12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓			
13. FATHER'S NAME <b>Joseph Caruso</b>				14. MOTHER'S MAIDEN NAME <b>Vincentina Damico</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>?</b>			
17. INFORMANT <b>Frances Caruso</b>				Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>1973-0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Brain tumor type unsheathed</b> DUE TO (c) <b>8 mos +</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 wks +</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 1956</b> to <b>Mar 4, 1961</b> , that I last saw the deceased alive on <b>March 2, 1961</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3501 Hamilton St</b> DATE SIGNED <b>3/5/61</b> ACTUAL SIGNATURE <b>Frank M. Trozzo Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>FRANK M. TROZZO JR MD. Hyattsville, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 8, 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>MAR 10 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Anthony L. K...</b>			

.. Dancer's Bone, Dancer's Bone, Dancer's Bone.

Serial 1001, March 10, 1901, Fort Lincoln Cemetery, Dancer's Bone.

FRANK M. DANCER, JR.  
3501 Dancer's Bone  
2/9/01

Handwritten notes and signatures, including "Dancer's Bone" and "Dancer's Bone".

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Handwritten notes and signatures, including "Dancer's Bone" and "Dancer's Bone".

CERTIFICATE OF DEATH

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1001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Form 283 3-27-61 MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
3407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
03396										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 31 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George County General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Ieland S. Caskey					4. DATE OF DEATH Month Day Year March 15 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-81		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Engineer					10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Robert Caskey					14. MOTHER'S MAIDEN NAME Sarah Ann Wiley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. 17. INFORMANT Hospital records					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 pyle/ty Pulmonary edema. Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) Right bronchogenic carcinoma (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of cervical region of right femur secondary to fall in home 19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home					20f. (City or town) (County) (State) Cheverly P. G. Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/16/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 18Mar'61					
22c. NAME OF CEMETERY OR CREMATORY Maryland Line Cem.					22d. LOCATION (City, town, or country) (State) Maryland Line, Md.					
23. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300-4th St. N.E. DC					24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE MAR 20 '61					



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 13 Film G283 3/29/61 jwk											
03397											
1. PLACE OF DEATH											
a. COUNTY Prince Georges County MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2819 64th Avenue											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
e. STATE District of Columbia											
f. COUNTY											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington											
d. STREET ADDRESS 1008 Shepherd Street N. E.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First MIDDLE Last HELEN Loretta Cavanagh											
4. DATE OF DEATH Month Year March 18, 19 61.											
5. SEX Female											
6. COLOR OR RACE White											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH December 29, 1894											
9. AGE (In years last birthday) 66											
IF UNDER 1 YEAR Months Days											
IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Retired											
10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.											
11. BIRTHPLACE (State or foreign country) Washington, D. C.											
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Richard A. Cavanagh											
14. MOTHER'S MAIDEN NAME Mary C. Powers											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No											
16. SOCIAL SECURITY NO. None											
17. INFORMANT Address Edward C. White, same as # 1											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the uterus											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED March 18, 1961											
ACTUAL SIGNATURE JAMES I. BOYD, M.D.											
EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
22b. DATE THEREOF 3-21-61											
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet											
22d. LOCATION (City, town, or country) Wash. DC											
23. FUNERAL DIRECTOR ADDRESS Timothy Haulon 3831-1a Ave NW											
24a. REC'D BY REGISTRAR DATE MAR 24 '61											
24b. REGISTRAR'S SIGNATURE Arthur S. Hines											





3409

## CERTIFICATE OF DEATH

Reg. Dist. No.

03398

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuxedo</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuxedo</b> 43			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>2305 59th. Ave.</b>				d. STREET ADDRESS <b>2305 59th. Ave.</b> 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ADA</b> First <b>CHORLEY</b> Middle Last				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 Oct 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Lee</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Mary R. Striker</b> <b>5900 Beecher Street</b> <b>Tuxedo, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syring carcinoma of sweat glands</b> 1919 DUE TO <b>in right inguinal, with Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>6 months</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 8</b> , 19 <b>60</b> , to <b>Mar 10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 9</b> , 19 <b>61</b> , and that death occurred at <b>7 a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>666 Maryland Ave., N.E.</b> DATE SIGNED <b>3/10/61</b> ACTUAL SIGNATURE <b>W.B. Morse</b> M.D. <b>Washington, D.C.</b> PHYSICIAN'S NAME (Type) <b>W.B. Morse</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/13/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3410

03399

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1320 - R. St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Christian</b> Middle <b>Christian</b> Last		4. DATE OF DEATH <b>March 17, 1961</b> Month <b>17</b> Day <b>1961</b> Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 16, 1906</b>		9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>- Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Moses Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Gengia ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Decedent</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Pyelonephritis with Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive and Arteriosclerotic cardiovascular disease; Diabetes Mellitus; Diffuse nodular Thyroid; Trophic ulcers, both lower extremities</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>March 15, 1961</b>	
20f. (City or town) <b>March 17, 1961</b>		(County) <b>1p.m.</b>		(State) <b>1961</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1961</b> to <b>March 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 17, 1961</b> , and that death occurred at <b>1p.m.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Moe Weiss</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	
23d. LOCATION (City, town or county) <b>Suitland, Maryland</b>		(State) <b>Maryland</b>		25a. REC'D BY REGISTRAR <b>W. Ernest Jarvis Co., Inc.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Ernest Jarvis Co., Inc.</b>		25b. REGISTRAR'S SIGNATURE <b>1432 You Street, N.W.</b>		25c. REGISTRAR'S SIGNATURE <b>1432 You Street, N.W.</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03400

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights</b> d. STREET ADDRESS <b>5706 Seminole Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>JAMES CLARENCE CLARKE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 61.</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1901</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operating Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't Agric.</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Clarke</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia ? FITZPATRICK</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Ruth E. Clarke, Berwyn Hgts., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>481X</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>March 9, 1961.</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				Address (Street, city, town, or county) <b>Bladensburg, Maryland.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-13-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Bladensburg, Maryland.</b>											
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.</b>				ADDRESS <b>Riverdale, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

MEDICAL CERTIFICATION

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JAMES I. DOTY, JR.

101 20th Lincoln Center



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 4813 Oglethorpe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JOHN JAMES CLARKE						4. DATE OF DEATH March 12, 19 61.																	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1921		9. AGE (In years not birthday) 39 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (State or foreign country) Penn'a.				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John Clarke						14. MOTHER'S MAIDEN NAME Anna Lesko																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES						16. SOCIAL SECURITY NO. UNKNOWN						17. INFORMANT Sgt. Charles J. Moyer, 330 Clark Street Tamaqua, Pennsylvania.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Acute Congestive Heart Failure DUE TO (b) Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Grippe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)				20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-16-61		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem. Homingdale Carbon Co. Pa.				22d. LOCATION (City, town, or country) (State)													
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md.				24a. REC'D BY REGISTRAR DATE APR 3 '61				24b. REGISTRAR'S SIGNATURE				25. DATE SIGNED March 12, 1961.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03402

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland,</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>E</b> Last <b>Clements</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 May 1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Russell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Walter J Clements Beltsville, Md.</b>	
17. INFORMANT <b>Walter J Clements Beltsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure &amp; Bilateral Hydrothorax</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction secondary to occlusion of anterior descending coronary artery.</b> DUE TO <b>11 days</b> (c) <b>Coronary Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred on <b>7, 50AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. A. Deitz, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Deitz, M.D.</b>		22d. ADDRESS <b>4314 Gallatin St. Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 9, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

3413

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
STATE OF MISSISSIPPI

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

NAME OF DECEASED

SEX

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

CHIEF CLERK

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3414 Item 2 Film G282 3-14-61 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **03403**

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md Arlington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Manor</b>		d. STREET ADDRESS <b>2815 S. 9th Street</b> <b>4922 La Salle Road</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Agnes Connor</b>		4. DATE OF DEATH <b>March 1st 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 20th 1891</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stenographer</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John P. Connor</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Agnes Meehan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>183-03-2472</b>	
17. INFORMANT Address <b>Alice Flynn 5017 Sentinel Drive Wash DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Bowel with Generalized Metastasis-</b> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>14 months-</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/3/1960</b> , 19, to <b>3/1/1961</b> , 19, that I last saw the deceased alive on <b>2/28/1961</b> , 19, and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. Collins</b> M.D.		ADDRESS (Street, city or town, state) <b>322- H. St. N.E.</b> DATE SIGNED <b>March 1, 1961</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Collins, M.D.</b>		<b>Washington 2, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Mattingly</b>		24. REC'D BY REGISTRAR <b>131-11th St</b> DATE <b>MAR 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			



CERTIFICATE OF DEATH

2014

MD-C3212



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3415 CERTIFICATE OF DEATH 03404											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) W Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 8022 14th Ave.					
3. NAME OF DECEASED (Type or print) Baby Girl Cooley						4. DATE OF DEATH March 22 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 March 1961		9. AGE (In years last birthday) yrs. 22		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Mitchel Cooley						14. MOTHER'S MAIDEN NAME Beverley Ann Schaff					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mother, Mrs Beverly Cooley Same					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 Respiratory failure DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 22 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
22c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 3/21 1961 to 3/22 1961, that (I) (we) last saw the deceased alive on 3/21 1961, and that death occurred at 1:05 AM from the causes and on the date stated above.											
22e. SIGNATURE Murray Paul, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/22/61			
22c. PHYSICIAN'S NAME (Type) MURRAY PAUL, M.D.						22d. ADDRESS 1017 University Blvd E. - Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORY Pr. Geo. General Hospital			23d. LOCATION (City, town or county) Cheverly, P.G.Co. Md (State)			
24. FUNERAL DIRECTOR'S SIGNATURE HARRY W. PENN						ADDRESS		25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Haus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3416

3416

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN IL <u>since 1945</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MT. RANIER</u> d. STREET ADDRESS <u>4105-34<sup>th</sup> ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANKLIN E. Corbin</u>		4. DATE OF DEATH <u>MARCH 22</u> 1961			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Clerk U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Ohio</u>	
13. FATHER'S NAME <u>Morris Jerome Corbin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Belle Corbin Kelch</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>3-1-1</u>		17. INFORMANT <u>Mrs. Pansy Mae Corbin, wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiogenic Carcinoma</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1961</u> to <u>March 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>61</u> , and that death occurred at <u>11:35</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>George William Ware</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Geo. W. Ware-M.D.</u>		22d. ADDRESS <u>1835 Eye St N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Ranier Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u>					

2015

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Prince George's

Chamber

Prince George's Chamber

Franklin

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George Washington  
The House of Representatives

George Washington

George Washington

George Washington

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03406

Item 10a, Film G-285 4/17/61, cag.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6401- Luman Lane</u>			d. STREET ADDRESS <u>16401- Luman Lane</u>		
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>Melvin</u> Last <u>Cardell</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4, 1921</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Rufus Cardell</u>		
14. MOTHER'S MAIDEN NAME <u>Laura Hamilton</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		
16. SOCIAL SECURITY NO. <u>240-26-0121</u>			17. INFORMANT <u>Mrs Nancy Cardell, same as #</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO (b) <u>Gun shot wound of the head</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>976X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head with a 12ga shotgun</u>		20c. TIME OF INJURY Month, Day, Year <u>Hour <u>11</u> <u>3-17-1961</u> <u>3 p.m.</u></u>			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Allentown</u>		20g. (County) <u>P.G. Co.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>James I. Boyd</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>3-18-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>3/21/61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMO-PK.</u>			22d. LOCATION (City, town, or country) (State) <u>SMITHFIELD, N.C.</u>		
23. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. 517 11<sup>TH</sup> ST. S.E.</u>			24a. REC'D BY REGISTRAR <u>MAR 21 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>					



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3415 MONDAY 10 OCTOBER 1950

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may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3418

03407

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloid Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Rebecca</u> Middle <u>Jane</u> Last <u>Council</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-'86</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sosiah Blackway</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>The Hospital Record</u> Address		18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Left Hemiplegia</u> DUE TO (c) <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Mar 20</u> 19 <u>61</u> , to <u>Mar 25</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 25</u> 19 <u>61</u> , and that death occurred at <u>9:50</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>LW Malin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>LW Malin MD</u>		22d. ADDRESS <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Salem Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wilmington Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1818

(M)

Francis Gash's son  
1 year 1 day

(P)

Francis Gash's son  
1 year 1 day  
Wilmington, Delaware  
1818

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please state the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
3419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
03408												
1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>4211, Colesville Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Henry Milton Crosswhite</b>						4. DATE OF DEATH Month <b>March</b> Day <b>20th.</b> Year <b>19 61</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 23, 1889</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk, Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>				11. BIRTHPLACE (State or foreign country) <b>Mountain City, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Grant Crosswhite</b>						14. MOTHER'S MAIDEN NAME <b>Kate Loyd</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>						
17. INFORMANT <b>Mrs. Alberta T. Crosswhite,</b>						Address <b>4211 Colesville Road, Hyattsville, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute Congestive heart failure</b> 442X DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor Md.</b>		(County) <b>Prince George's</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 20th, 1961</b> Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Colmar Manor Md.</b>				
23. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville Md.</b>						ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		

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Prince George's

Kingston

Prince George's

Queen's

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Prince George's

Kingston

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03409											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Page</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>						c. LENGTH OF STAY IN lb <b>D. O. A.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						e. STREET ADDRESS <b>Stanley</b>					
3. NAME OF DECEASED (Type or print) <b>Ellis James Cabbage</b>						4. DATE OF DEATH <b>March 31, 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1913</b>		9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Cabbage</b>						14. MOTHER'S MAIDEN NAME <b>Lucy Pence</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>unknown</b>					
17. INFORMANT <b>Mrs Rita Hamilton</b>						Address <b>5202 Quincey Street, Bladensburg, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>TUBERCULOSIS, LUNG, BILATERAL, FAR ADVANCED</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>James I. Boyd</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/31/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>4-4-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sigler Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Stanley, Virginia</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Rockville, Md.</b>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>A. J. S. Hines</b>			
DATE <b>APR 4 '61</b>											



NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

FORWARDED BY [illegible]  
TO [illegible]

RECEIVED BY [illegible]  
DATE [illegible]



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

3421 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03410

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENDALE</b>		d. STREET ADDRESS <b>Box 1 P.O. #362</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LELAND MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BIRRELL</b> Middle <b>WESLEY</b> Last <b>CUPPETT</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 21, 1903</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. CIVIL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob H. Cuppett</b>				14. MOTHER'S MAIDEN NAME <b>Edith I. Schenk</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Geneva Cuppett</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NECROTIZING DIVERTICULITIS</b> 572 } DUE TO (b) <b>DIVERTICULOSIS, LARGE INTESTINE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EDEMA</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>March 4, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Bladensburg, Md</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please state the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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3422 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill</b> c. LENGTH OF STAY IN lb <b>1 Year</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2605 Southern Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill</b> d. STREET ADDRESS <b>2605 Southern Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAURENCE FRANCIS CURTIN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27,</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1913</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Laurence Curtin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Agnes Flynn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ruth M. Curtin,</b>		Address <b>2605 Southern Ave., Oxen Hill, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>THROMBOSIS CORONARY ARTERY</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SUBARACHNOID HEMORRHAGE</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 27, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 Mar. 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem - Wash.</b>		22d. LOCATION (City, town, or country) (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR <b>Lee Funeral Home</b>				ADDRESS <b>300-4th St NE</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Curtis L. Kline</b>			

FOR STATE  
DEPT. OF JUSTICE

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3133

3133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11/11/1913

James George Young	George Young	James George Young
Oscar Hill	Oscar Hill	Oscar Hill
2807 Southern Avenue	2807 Southern Avenue	2807 Southern Avenue
St. Louis, Mo.	St. Louis, Mo.	St. Louis, Mo.
Nov. 11, 1913	Nov. 11, 1913	Nov. 11, 1913
Joseph	Joseph	Joseph
Lawrence J. Young	Lawrence J. Young	Lawrence J. Young
2807 Southern Avenue	2807 Southern Avenue	2807 Southern Avenue
St. Louis, Mo.	St. Louis, Mo.	St. Louis, Mo.
Nov. 11, 1913	Nov. 11, 1913	Nov. 11, 1913

*[Faint, mostly illegible text and signatures follow, including what appears to be a signature of "James I. ..."]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3423

## CERTIFICATE OF DEATH

03412

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 Hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>3105 Rosemary Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ruth E. Dahl</u>				<b>4. DATE OF DEATH</b> Month <u>Mar.</u> Day <u>29</u> Year <u>19 61</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept 1, 1897</u>	
<b>9. AGE</b> (In years last birthday) <u>63</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MINNESOTA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Andrew Carlson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Mr Harriet Ellison, Same as #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Atrial fibrillation</u> DUE TO (b) <u>2. Congestive Heart Failure</u> DUE TO (c) <u>3. Diabetes Mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>15-20 min</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1960</u> <b>to</b> <u>March 29, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 29, 1961</u> <b>and that death occurred at</b> <u>3:55 P</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Peter Dunis</u>				<b>22b. DATE SIGNED</b> <u>3-31-61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>PETER DUNIS</u>				<b>22d. ADDRESS</b> <u>PRINCE GEORGE'S HOSPITAL, CHEVERLY, MD</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>4-3-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CAK HILL CEMETERY</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>MINNEAPOLIS, MINNESOTA</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Co. Rincdale Md</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE APR 4 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	



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Handwritten notes and signatures, including "PETER DAVIS" and "MINNEAPOLIS HOSPITAL".



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03413

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
c. LENGTH OF STAY IN 1b <u>10 1/2 Yrs</u>				d. STREET ADDRESS <u>4527-38th St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>FRANCIS</u> Middle <u>DAY</u> Last				4. DATE OF DEATH <u>March 26</u> Month <u>26</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer Bt, Dept Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Connecticut</u>		11. BIRTHPLACE (State or foreign country) <u>U S A.</u>	
13. FATHER'S NAME <u>John Francis Day</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Apr 42 to Apr 43</u>				17. INFORMANT <u>Mrs Esther Day</u> Address <u>4527-38th St.</u>			
16. SOCIAL SECURITY NO. <u>—</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis - Bronchial asthma</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>61</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>March 19, 1961</u> to <u>March 26, 1961</u> , that I last saw the deceased alive on <u>March 24, 1961</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Bowne</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CHARLES J. BOWNE MD</u>							
22a. BURIAL, CREMATION, <u>REMOVED</u>		22b. DATE THEREOF <u>3-29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myers, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee's Sons Co.</u> ADDRESS <u>300-4th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3425

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03414

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. LENGTH OF STAY IN 1b <u>1MO-27 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SWITLAND NURSING Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PAUL</u> First <u>DE</u> Middle <u>BOURG</u> Last				4. DATE OF DEATH Month <u>MAR</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB-25-1877</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
12. CITIZEN OF WHAT COUNTRY? <u>us</u>							
13. FATHER'S NAME <u>Knut Stape</u>				14. MOTHER'S MAIDEN NAME <u>Karar Oder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>PAUL R. DeBOURG</u> Address <u>7505 FOSTER ST. DIST HIGHTS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>2-16-61</u> 19 <u>61</u> , to <u>March 25</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 24</u> 19 <u>61</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Cleary</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-25-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Cleary</u>				22d. ADDRESS <u>5556 Silver Hill Road S. E. Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Semmers Bros</u> ADDRESS <u>1661 - Good Hope Rd S E Wash DC</u>				25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3426

03415

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Lanham</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>9126 Alcona Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Decker</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Mar 1961</b>		9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles E Decker</b>				14. MOTHER'S MAIDEN NAME <b>Joyce Savage</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0 cerebral anoxia</b> DUE TO (b) <b>atalectasis</b> DUE TO (c) <b>20 hrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 Mar 11 Mar 1961</b> , that (I) (we) last saw the deceased alive on <b>11 Mar 1961</b> , and that death occurred at <b>11:00AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Fred. Musser., M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Fred. Musser., M.D.</b>				22d. ADDRESS <b>4410 74th Ave. Bellemead., Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg Rd. Wash D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home, Mt. Rainier, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Robert S. Harris</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03417

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>1019 8th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Florence Dove</b>				4. DATE OF DEATH Month Day Year <b>March 7 1961</b>															
5. SEX <b>Fe.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-11-84</b>		9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days <b>76</b>		IF UNDER 24 HRS. Hours Min. <b>76</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Franklin, West Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Elijah Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Simpson</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>Plato Dove, Laurel, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral Thrombosis</b> (c), stating the underlying cause last. DUE TO <b>Generalized Arteriosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>12 days</b> <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> , 19 <b>61</b> to <b>3/7</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>2:30 PM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Norman D. Comeau</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>Dr. Norman D. Comeau</b> 22d. ADDRESS <b>3503 Perry St. Mt. Rainier, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>March 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Laurel, Md.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Donaldson</b>				25a. REC'D BY REGISTRAR <b>14 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>											



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MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

03418

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12-- 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mt Rainier</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>1 4004 36th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Torey</b>		First <b>Jan</b>		Middle <b>Dunn</b>		Last			
5. SEX <b>Fe.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>March 24 19 61</b>			
9. AGE (In years last birthday) <b>March 23, 1961</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>John S Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Christobel Carter</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Christobel Dunn</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal artery (artery)</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 23 19 61</b> to <b>Mar. 24 19 61</b> , that (I) (we) last saw the deceased alive <b>March 24 19 61</b> , and that death occurred at <b>7 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W.C. Etienne</b>				22b. DATE SIGNED <b>3/27/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>W.C. ETIENNE</b>				22d. ADDRESS <b>College Park, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3/31/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. General Hospital</b>		23d. LOCATION (City, town, or county) (State) <b>Cheverly, P.G. County, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HARRY W. PENN</b>				25a. REC'D BY REGISTRAR <b>APR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Christobel Dunn</b>			

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WESTINGHOUSE STATEMENT OF HEALTH  
STATEMENT OF DEATH

1928

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NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
DISEASE  
AGE  
SEX  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
CHILDREN  
SIBLINGS  
PARENTS  
BROTHERS  
SISTERS  
GRANDPARENTS  
AUNT  
UNCLE  
Nephew  
Niece  
Cousin  
Other

(Signature)

TO THE  
OF THE  
BY  
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3429

## CERTIFICATE OF DEATH

03419

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>70</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> f. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4906 Branchville RD</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM A. DUVAL</b>		4. DATE OF DEATH <b>3 - 18 - 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-81</b>
9. AGE (in years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Scaffolding co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>John Duvall</b>	
14. MOTHER'S MAIDEN NAME <b>? Wilson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Wm A. Duvall Jr</b> Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>420.0</b> DUE TO (b) <b>Cerebral sclerosis H &amp; L disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Edema - Ca of Ascending Colon</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-24-1961</b> to <b>3-18-1961</b> , that (I) (we) last saw the deceased alive on <b>3-18-1961</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Schwartzbach</b>		22b. DATE SIGNED <b>March 18, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. Schwartzbach</b>		22d. ADDRESS <b>1726 I st N W Washington D C</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>3/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Mausoleum</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 21 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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15M 9/60

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1892-1893

W. J. Sullivan

SECRET



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3430

## CERTIFICATE OF DEATH

Reg. Dist. No. 03421

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Va.</u> b. COUNTY <u>Greenboro</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				c. LENGTH OF STAY IN 1b <u>1 wk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Renick</u>			
3. NAME OF DECEASED (Type or print) First <u>LEAFIE</u> Middle <u>FARLEY</u> Last <u>FARLEY</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u> <u>1907</u> <u>53</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Newton Blake</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Poe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>R.E. Scott, Accokeek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO <u>Cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 yr</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis oc cervical spine</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 27</u> , 19 <u>61</u> , to <u>Mar 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>61</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.				DATE SIGNED <u>Accokeek</u>			
PHYSICIAN'S NAME (Type) <u>Paul Chen, M. D.</u>				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Renick, West Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please state the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03423											
1. PLACE OF DEATH											
a. COUNTY Prince George's MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly 13 days											
c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. STATE Maryland b. COUNTY Prince Georges											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore West Hyattsville											
d. STREET ADDRESS 238 S. Loudon Avenue 5805 Queens Chapel Road											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Agnes Middle M A. Last Fitzsimmons											
4. DATE OF DEATH March 10, 19 61											
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH January 27, 1876 9. AGE (In years last birthday) 85											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME James Fitzsimmons 14. MOTHER'S MAIDEN NAME Mary Reynolds											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Hospital Records Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia											
904.7 DUE TO (b) Intertrochanteric fracture of the left hip											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced cardiovascular renal disease											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell and fractured hip at Sacred Heart Nursing Home											
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 3/25/61 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Hyattsville P. G. (County) Md. (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion, death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) James I. Boyd ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/11/61											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3/13/61 22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL 22d. LOCATION (City, town, or country) BALTIMORE, MD. (State)											
23. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT ST. ADDRESS											
24a. REC'D BY REGISTRAR DATE MAR 14 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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U. S. ARMY - 2nd INFANTRY DIVISION

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03424

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b> d. STREET ADDRESS <b>5005 36th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>Floyd Fay Fox</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1899</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Supervisor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				11. BIRTHPLACE <b>Ohio</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Albert A. Fox</b>								14. MOTHER'S MAIDEN NAME <b>Nora Bowerize</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>1919-1922</b>								16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Callie Fox, Same as # 2</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic heart disease, auricular fibrillation</b> (c) <b>DUE TO</b> (e), stating the underlying cause last.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>3/11/61</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				Address (Street, city, town, or county)													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/14/61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>					
23. FUNERAL DIRECTOR <b>Malley's Funeral Home</b>				ADDRESS <b>14th Rowles Rd.</b>				24a. REC'D BY REGISTRAR <b>md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>				DATE <b>MAR 16 '61</b>	

MEDICAL CERTIFICATION



SEPC

1. The first step is to identify the problem or question that needs to be answered.

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None Reported

DOI: 10.1002/for

Cellio Inc., 2000

100-443887-100

10/22/5.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
3433 Item 8 Film G284 4/4/61 iwk 03425											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 1 mo 11 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General						d. STREET ADDRESS 5103 Indian Avenue					
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 11/2/86 1886					
9. AGE (In years last birthday) 74 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired						11. BIRTHPLACE (County & State, or foreign country) U S A					
12. CITIZEN OF WHAT COUNTRY? U S A						13. FATHER'S NAME Jacob Frantz					
14. MOTHER'S MAIDEN NAME Mary Neiswender						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					
16. SOCIAL SECURITY NO. no						17. INFORMANT Address Eleanor J Frantz College Park, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 332x DUE TO Cerebral Thrombosis due to Arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (b) hemiplegia INTERVAL BETWEEN ONSET AND DEATH 7 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1961 to Mar. 20, 1961 that (I) (we) last saw the deceased alive on Mar. 20, 1961 and that death occurred on Mar. 20, 1961 at 9:55 a.m. from the causes and on the date stated above.											
22a. SIGNATURE Dr. Peter Duus. M.D. M.D.											
22b. DATE SIGNED 3/21/61											
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus. M.D.											
22d. ADDRESS 61 24 Central Ave., Capitol Heights, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 3/23/61											
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery											
23d. LOCATION (City, town or county) Colmar Manor Md. (State)											
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md. ADDRESS											
25a. REC'D BY REGISTRAR DATE MAR 22 '61											
25b. REGISTRAR'S SIGNATURE											

M

(At diagnosis)  
Arteriosclerosis  
Cerebral Thrombosis due to

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03426									
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WEST HYATTSVILLE</b> c. LENGTH OF STAY IN <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2000 FORDHAM STREET</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WEST HYATTSVILLE</b> d. STREET ADDRESS <b>2000 FORDHAM STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>STEVEN ANTHONY GALIFARO</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>19 61</b>				
5. SEX <b>MALE</b>					6. COLOR OR RACE <b>CAUCASIAN</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>NOV. 1, 1960</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>THOMAS J. GALIFARO, JR.</b>					14. MOTHER'S MAIDEN NAME <b>MARY V. ROY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>THOMAS J. GALIFARO, JR.</b>					Address <b>SAME AS #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion: death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>MARCH 5, 1961</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>Mar-7, 1961</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN, CEM.</b>					22d. LOCATION (City, town, or country) (State) <b>WHEATON, MARYLAND</b>				
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Funeral Dir.</b>					24a. REC'D BY REGISTRAR <b>MAR 7 '61</b> DATE				
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>									

2075193 XV6

THE TAIL  
FLUID UNIT

(M)

(C)

2020

WILSON GEORGE

1011 E. 10TH ST.

2000 LOUISIANA STREET

STREET

CHICAGO

WILSON

WILSON

THOMAS A. GILBERT, JR.

NO

WILSON

WILSON

WILSON F. WILSON

THOMAS J. GILBERT, JR.

*James I. Wilson*

*James I. Wilson*

JAMES I. WILSON

MARCH 5, 1961

WILSON F. WILSON  
WILSON F. WILSON  
WILSON F. WILSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

3435

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03435

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial</i>		d. STREET ADDRESS <i>7405 Columbia Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Charlie</i> First <i>O.</i> Middle <i>G.</i> Last <i>Goins</i>		4. DATE OF DEATH <i>March 14</i> 19 <i>61</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-31-99</i>
9. AGE (In years lost birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>coal Miner</i>	
11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Williams Goins</i>		14. MOTHER'S MAIDEN NAME <i>Belle Bray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>403 03 5670</i>	
17. INFORMANT <i>Hospital Records - Riverdale, Ind</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branchogenic Carcinoma</i> DUE TO (b) <i>162.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Benign prostatic hypertrophy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2-15</i> 19 <i>60</i> to <i>3-14</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>3-14</i> 19 <i>61</i> , and that death occurred at <i>10:48</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>D.R. Purdie</i> M.D.		22b. DATE SIGNED <i>3/14/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>D.R. PURDIE</i>		22d. ADDRESS <i>Quensbury Rd Riverdale Ind</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		23b. DATE THEREOF <i>3/15/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Williamsburg</i>		23d. LOCATION (City, town, or county) (State) <i>Kentucky</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasch's Sons</i> ADDRESS <i>Hyattsville Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 20 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

5035

*[Faint, mostly illegible text, likely a form for a death certificate. Some legible fragments include:]*

*NAME OF DECEASED*  
*DATE OF DEATH*  
*PLACE OF DEATH*  
*CAUSE OF DEATH*  
*TESTED BY*  
*SIGNATURE OF DECEASED*  
*SIGNATURE OF WITNESSES*  
*SIGNATURE OF UNDERTAKER*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please sign the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A1SME  
5M 7/59

MEDICAL CERTIFICATION

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

JAMES I. BOYD, M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3-20-1961

22c. NAME OF CEMETERY OR CREMATORY

FORT LINCOLN CEM.

22d. LOCATION (City, town, or county)

BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR

ADDRESS

W.W. Chambers & Co. Riverdale, Md

24a. REC'D BY REGISTRAR

DATE MAR 21 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03428

1. PLACE OF DEATH

a. COUNTY

Prince Georges County

MARYLAND

b. CITY OR TOWN (If outside corporate limits,  
write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY in 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

d. STREET ADDRESS

4908 Ravenswood Road

a. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

3. NAME OF  
DECEASED  
(Type or print)

Joseph

Pascal

Gossett

4. DATE  
OF  
DEATH

March

16,

19 61.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 21, 1906

9. AGE (In years  
last birthday)

54 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Superintendent

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

M. T. Gossett

14. MOTHER'S MAIDEN NAME

Jodie Bagwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-12-1160

17. INFORMANT

Mrs Elizabeth Gossett, same as # 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Coronary atherosclerosis

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.  
p.m.

19

20d. INJURY OCCURRED

While ☐ Not While ☐  
at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Address (Street, city, town, or county)

March 16, 1961.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3-20-1961

22c. NAME OF CEMETERY OR CREMATORY

FORT LINCOLN CEM.

22d. LOCATION (City, town, or county)

BLADENSBURG, MARYLAND

(State)

3536

1-11-60

10181500, 10181501

Germany's efforts are

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3437

## CERTIFICATE OF DEATH

Reg. Dist. No. 03429

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Weber Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph First Middle Last Gotch		4. DATE OF DEATH March 3rd 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1880
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Susan Koltar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705-09-2481	
17. INFORMANT Address Anna Gotch 19 Weber Drive District Hgts			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjestive Heart Failure DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 3/3, 1961, that I last saw the deceased alive on 3/12, 1961, and that death occurred at 12:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-3-6/DATE SIGNED ACTUAL SIGNATURE Lewis Parker M.D. 5241 St Barnabas Rd Temple Hill, MD PHYSICIAN'S NAME (Type) Lewis Parker			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-1961	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly		24a. REC'D BY REGISTRAR DATE MAR 8 '61	
ADDRESS 131 11th S.E. Wash D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LAST

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-28		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 N. W. 10th St., Baltimore, Md.		Author		Suicide		Suicide		12-1-68		Baltimore, Md.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES EARL RAY, JR.		JAMES EARL RAY, SR.		JAMES EARL RAY, SR.		JAMES EARL RAY, SR.		High School		Catholic	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
12-1-68		Baltimore, Md.		Suicide		Suicide		12-1-68		Baltimore, Md.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES EARL RAY, JR.		JAMES EARL RAY, SR.		JAMES EARL RAY, SR.		JAMES EARL RAY, SR.		High School		Catholic	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03430

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>D. O. S</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>14426 Powder Mill Road</b>			
3. NAME OF DECEASED (Type or print) <b>Julius Carlton Gray</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 20, 1960</b>	
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>		IF UNDER 24 HRS. Hours <b>3</b> Min. <b>3</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Julius Carlton Gray Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Rosalee Meadows</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Rosalee Gray, same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Smothering in plastic covering on bed</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Face was covered with plastic bag that was on bed</b>			
20c. TIME OF INJURY Month, Day, Year <b>3/25/ 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Beltsville P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>March 25, 1961</b>			
				Address (Street, city, town, or county) <b>Rockville, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church</b>		22d. LOCATION (City, town, or country) (State) <b>Murkirk, Md</b>	
23. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				24a. REC'D BY REGISTRAR <b>March 30 '61</b>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

2077201xv4



FOR THE  
HEALTH UNIT

(M)

3433

France Joseph

Joseph

France Joseph

Joseph

A. J. A.

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France Joseph, born at [illegible]

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U. S. A.

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]

Joseph, born at [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3439 <b>CERTIFICATE OF DEATH</b> 03431									
Item 5 from Birth certificate 4/4/61 iwk									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 1:Hour 24 Min. X Upper Marlboro				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					e. STREET ADDRESS Box 3347 R.F.D.				
3. NAME OF DECEASED (Type or print) Baby					4. DATE OF DEATH Mar. 22 1961				
5. SEX Male					6. COLOR OR RACE Colored				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Mar. 22, 1961				
9. AGE (In years last birthday) yrs.					10. IF UNDER 1 YEAR Months Days				
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joseph Greenwell					14. MOTHER'S MAIDEN NAME Geneva Sellman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mother					Address Geneva Greenwell Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atelectasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Mar. 22, 1961 to Mar. 22, 1961, that (I) (we) last saw the deceased alive on Mar. 22, 1961, and that death occurred at 2:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Thomas A. Christensen M.D.									
22b. DATE SIGNED 3/24/61									
22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen									
22d. ADDRESS Balto. Ave., College Park, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation									
23b. DATE THEREOF 3/31/61									
23c. NAME OF CEMETERY OR CREMATORY Pr. Geo. General Hospital									
23d. LOCATION (City/town or county) (State) Cheverly, P.G. County, Md.									
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS HARRY W. PENN									
25a. REC'D BY REGISTRAR DATE APR 3 '61									
25b. REGISTRAR'S SIGNATURE Charles S. Kraus									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

1  
3440  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03432

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGES</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. LENGTH OF STAY IN 1b <i>34 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Deland Memorial</i>		d. STREET ADDRESS <i>5009 Lakeland Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carrie Agnes Guss</i>		4. DATE OF DEATH Month <i>3</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-10-1870</i>
9. AGE (In years lost birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James C Guss</i>		14. MOTHER'S M maiden NAME <i>Carrie Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Amos Guss</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerotic Generalized</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic pyelonephritis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1959</i> to <i>3-20-61</i> , that (I) (we) lost the deceased alive on <i>3-20</i> 19 <i>61</i> , and that death occurred at <i>1:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Gurdie</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-23-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Nativity Heaven</i>		23d. LOCATION (City, town, or county) (State) <i>Wheaton Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Washington</i>		25a. REG'D BY REGISTRAR <i>MAR 27 1961</i>	
ADDRESS <i>4925 Dean Ave</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Travis</i>	

145

1940

1940

1. Name of deceased: *John A. Smith*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *March 15, 1895*  
5. Place of birth: *Washington, D.C.*  
6. Date of death: *April 10, 1940*  
7. Place of death: *Home*  
8. Cause of death: *Heart disease*  
9. Duration of illness: *Several days*  
10. Name of physician: *Dr. J. H. Jones*  
11. Name of funeral home: *None*  
12. Name of informant: *John A. Smith*  
13. Address of informant: *123 Main St., Baltimore, Md.*  
14. Signature of informant: *[Signature]*  
15. Signature of physician: *[Signature]*  
16. Signature of funeral home: *[Signature]*  
17. Signature of informant: *[Signature]*  
18. Signature of informant: *[Signature]*  
19. Signature of informant: *[Signature]*  
20. Signature of informant: *[Signature]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03433											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights 18 d. STREET ADDRESS 2210 Jameson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Jeannette Cecilia Guth						4. DATE OF DEATH Month Day Year March 29, 19 61.					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1904 57		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Dean						14. MOTHER'S MAIDEN NAME Amanda Gray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. Frank C. Guth Jr. same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema and Fatty Infiltration Liver 871.0 DUE TO (b) Pending Acute meprobamate poisoning Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took an overdose of meprobamate. Was mentally disturbed.							
20c. TIME OF INJURY Month, Day, Year Hour <del>xxx</del> p.m. 3-29 1961				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hillcrest Hgts P.G. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 29, 1961.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-3-61		22c. NAME OF CEMETERY OR CREMATORY Washington Natl		22d. LOCATION (City, town, or country) (State) Suitland Md.			
23. FUNERAL DIRECTOR ADDRESS H. G. Good Hope Rd. Wash. D.C.						24a. REC'D BY REGISTRAR APR 3 '61		24b. REGISTRAR'S SIGNATURE William L. Thurst			

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CERTIFICATE OF DEATH

1914



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3443											
03435											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jefferson Heights d. STREET ADDRESS 1012 56th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Daisey (Daisy) Hammond			4. DATE OF DEATH Month Day Year March 16 1961								
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 8, 1884		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Atlanta, Georgia			
13. FATHER'S NAME Charles Frambro				14. MOTHER'S MAIDEN NAME Agnes Shell				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If assigned or date of service)				17. INFORMANT Address Clarence F. Hammond, Jr. 1012 56 Pl.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Ruptured Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (b) Int. atherosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mar. 14, 1961		20f. (County) Mar. 16, 1961	
21. I certify that (I) (this hospital) attended the deceased from March 16, 1961, to March 16, 1961, that (I) (we) last saw the deceased alive on March 16, 1961, and that death occurred at 9:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Dr. David S. Clayman				22b. DATE 3-17-61		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dr. David S. Clayman M.D.				22d. ADDRESS 6311 Baltimore Ave., Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-22-61		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		23d. LOCATION (City, town or county) Beltsville, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Address				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bellevue, Myrtle K. 4339 N. 11th St. N.E.				MAR 21 '61		Charles S. Hume					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03436

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		
c. LENGTH OF STAY in 1b <u>2 hours</u>			d. STREET ADDRESS <u>Box 387</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Maryland Hospital Center</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Lucy Mae Hanes</u>			4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1913</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>47</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Jerome Whitehead</u>		
14. MOTHER'S MAIDEN NAME <u>Lucy Mae Nepper</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Brenda Joyce Stevenson</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			22b. DATE THEREOF <u>3-3-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>The Hunt Funeral Home, Waldorf, Md.</u>			22d. LOCATION (City, town, or country) (State) <u>Waldorf, Va.</u>		
23. FUNERAL DIRECTOR ADDRESS <u>The Hunt Funeral Home, Waldorf, Md.</u>			24a. REC'D BY REGISTRAR <u>MAR 6 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>			DATE SIGNED <u>March 2, 1961</u>		

MEDICAL CERTIFICATION

UNITED STATES  
DEPARTMENT OF HEALTH



RECEIVED  
JAN 10 1941  
U.S. DEPT. OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1941  
U.S. DEPT. OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D.C.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03437

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN 1b <u>4 hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hospital Center Star Route #2</u>				d. STREET ADDRESS <u>La Plata</u> <u>08x2</u>			
3. NAME OF DECEASED (Type or print) <u>Janet Lee Hanson</u>				4. DATE OF DEATH <u>March 16 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4, 1956</u> 4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. - C</u>	
13. FATHER'S NAME <u>John Dudley Hanson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bowie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John D. Hanson, son</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac arrest</u> 550.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Vinethane - Ether Anesthesia</u> cause listed. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occurred during adenoid tonsillectomy</u>					
20c. TIME OF INJURY <u>10:00 a.m.</u> <u>3/16 1961</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>at work</u> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) <u>Clinton</u> (County) <u>Pg.</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James S. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>3-16-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or country) (State) <u>Pomfret, Maryland</u>	
23. FUNERAL DIRECTOR <u>Hunt &amp; Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

See Page 294

1

3446

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03438

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>years</u>		d. STREET ADDRESS <u>1913 Blagwood Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>913 Blagwood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>B.</u> Last <u>HECHMER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorton, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Luethke</u>		14. MOTHER'S MAIDEN NAME <u>Maria Fredrickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Mildred M. Hechmer (same as #2)</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Senile Arteriosclerosis Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>40 Hours</u> 10 Yrs 10 M			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>13 March</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>13 Mar</u> 19 <u>61</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. B. Queen</u>		22b. DATE SIGNED <u>13 Mar 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 17, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bluemont Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dorton, West Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Juritha Walters, 254 Carroll St N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>  </u>		DATE <u>MAR 16 '61</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3447

CERTIFICATE OF DEATH

Reg. Dist. No. 03439

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b 14 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 29			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6301-Forte Street				d. STREET ADDRESS 6301-Forte Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle MAE Last HENDERSON				4. DATE OF DEATH Month March Day 1 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Crawford.				14. MOTHER'S MAIDEN NAME Rose Stant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-14-5018		INFORMANT Address Mr. Clyde A. Henderson - 6301-Forte St SE 1st Flr 2nd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary heart disease 6 years. (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1955, to March 1, 1961, that I last saw the deceased alive on March 1, 1961, and that death occurred at 9:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 6124 Central Ave DATE SIGNED 3/1/61			
PHYSICIAN'S NAME (Type) WM BRAININ				Capitol Hgts Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/4/61		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co. Inc. 517-11th St. S.E.				24a. REC'D BY REGISTRAR DATE MAR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

03130

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not a resident of the State, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div>3448</div> <div>Item 14 Film G284 4/12/61 iwk</div> <div>03440</div> </div> <div> <div>3448</div> <div>CERTIFICATE OF DEATH</div> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>Box 317 Route #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Rose</b> Middle <b>Josephine</b> Last <b>Herbert</b>						<b>4. DATE OF DEATH</b> Month <b>3-</b> Day <b>31</b> Year <b>19 61</b>							
<b>5. SEX</b> <b>Fe/</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-4- 19 00</b>		<b>9. AGE (In years last birthday)</b> <b>60 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Same</b>							
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Md.</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Joseph Panowicz</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine unknown</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>						<b>16. SOCIAL SECURITY NO.</b> <b>no</b>							
<b>17. INFORMANT</b> <b>Francis Herbert, Laurel Md</b>						<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar Artery Thrombosis</b> (b) <b>332X</b> DUE TO <b>Hypertens. Art. Scl. Vasc. Dis.</b> (c) <b>Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., and the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>X Richard Compton</b> M.D.						<b>22b. DATE SIGNED</b> <b>APR 7 '61</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Richard J. Compton, M.D.</b>						<b>22d. ADDRESS</b> <b>612 Main Street</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>						<b>23b. DATE THEREOF</b> <b>April 3, 1961</b>							
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Mary Cemetery</b>						<b>23d. LOCATION (City, town or county)</b> <b>Laurel Md</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>D. W. Donaldson</b>						<b>25a. RECEIVED BY REGISTRAR</b> <b>APR 7 '61</b>							
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>													

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3440

3441

**CERTIFICATE OF DEATH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				d. STREET ADDRESS <b>308 Main Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Lauree</b> Last <b>Hershberger</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-1897</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George Edward Diven</b>				14. MOTHER'S MAIDEN NAME <b>Dora Ellen Snapp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-20-3005</b>			
17. INFORMANT <b>Miss Lauretta Brown, Laurel Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver, L Aenwei's</b> 581-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>3 mos</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 9 1961</b> to <b>MARCH 5 1961</b> , that (I) (we) last saw the deceased alive on <b>MARCH 5 1961</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Norman Donat (M.D.)</b>				22b. DATE SIGNED <b>3/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT (M.D.)</b>				22d. ADDRESS <b>3503 PERRY ST MT RAINIER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 8, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anglican Cemetery Laurel Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Donaldson Laurel</b>				25a. RECEIVED BY REGISTRAR DATE <b>MAR 14 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

OP

CERTIFICATE OF DEATH

1968

10-10-68

Full name of deceased: *John Doe*  
Date of birth: *10-10-1900*  
Sex: *Male*  
Race: *White*  
Marital status: *Married*  
Place of birth: *New York, N.Y.*  
Usual residence: *123 Main St., New York, N.Y.*  
Cause of death: *Heart Disease*

Immediate cause of death: *Myocardial infarction*  
Underlying cause of death: *Atherosclerosis*  
Manner of death: *Natural*

Physician's signature: *Dr. J. K. Smith*  
Physician's address: *456 Medical Bldg., New York, N.Y.*  
Date of death: *10-10-68*  
Time of death: *10:00 AM*  
Place of death: *Home*

Signature of informant: *John Doe*  
Signature of physician: *Dr. J. K. Smith*  
Signature of registrar: *John Doe*  
Signature of funeral director: *John Doe*

Signature of medical examiner: *John Doe*  
Signature of coroner: *John Doe*  
Signature of health officer: *John Doe*  
Signature of registrar: *John Doe*

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

3450  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03442

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN b <b>45 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <b>1 4919 49th Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Emma M Hodgkins</b>				4. DATE OF DEATH <b>March 28 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 Feb 1869</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>CHESTERTOWN. MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Cardiovascular renal disease</b> (c) <b>Fracture of the head of the left femur</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home and injured hip</b>			
20c. TIME OF INJURY Month, Day, Year <b>2:00 p.m. 2/11 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Edmonston P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>3/29/61</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-1-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Chester town, Maryland</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>				24. REC'D BY REGISTRAR <b>APR 3 '61</b>			
ADDRESS <b>Pinerdale, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>W. L. Evans</b>			

MEDICAL CERTIFICATION

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Mr. J. H. [illegible]

London

London

Residential [illegible]

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Residential [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3451

## CERTIFICATE OF DEATH

03443

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General</b>				d. STREET ADDRESS <b>136 Lafayette St.</b>			
3. NAME OF DECEASED (Type or print) <b>Mary Hutchinson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-12-1898</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Laurel, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Sadelik</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Miss Josephine Bozovitch, Laurel Md</b>				Address <b>Laurel Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Acute Pul. Edema</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arterio sclerotic Ht &amp; Bt</b> (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred <b>7:30 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Peter Rivers</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>March 11, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Laurel Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Donahoe</b>				ADDRESS <b>Laurel Md</b>		25a. REC'D BY REGISTRAR <b>MAR 15 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Deputy Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**3452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03444

1. PLACE OF DEATH e. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4800 LAGUNA ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NETTIE</b>		First Middle Last <b>IMMEL</b>		4. DATE OF DEATH Month Day Year <b>MARCH 13, 1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1888</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John William Saltzer</b>				14. MOTHER'S MAIDEN NAME <b>Emma Mountz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>188-09-9132A</b>		17. INFORMANT <b>Betty M. Swope, Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Profound secondary anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the ileocecal junction</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>MARCH 13, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hope Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Myerstown, Penna</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Co. Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 15 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hall</i>	

MEDICAL CERTIFICATION

NO. 1011  
MAY 1961

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RECEIVED  
MAY 1961

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MASTERS STATE UNIVERSITY  
STATISTICAL RESEARCH AND RECORDS SECTION  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3453									
03445									
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>cheverly</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>6407 - 24<sup>th</sup> Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Nicholas</u>		4. DATE OF DEATH <u>3</u> Month <u>13</u> Day <u>19</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		13. FATHER'S NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>7-20-1917-5-14-19 086-12-3375</u>		17. INFORMANT <u>Boris IVKO, Son Same as #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.0</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Cerebral - Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> , 19 <u>61</u> , to <u>3-13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-13</u> , 19 <u>61</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>A. Deitz</u>		22c. PHYSICIAN'S NAME (Type) <u>DR. A. Deitz</u>		22d. ADDRESS <u>Hyattsville, Md</u>		22b. DATE SIGNED <u>3-13-61</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		23d. LOCATION (City, town or county) (State) <u>FT MYER VA</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>5801 Cleveland Ave Bowie, Md</u>	
25a. REC'D BY REGISTRAR <u>15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>		25c. DATE		25d.		25e.	

2003

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From: [illegible]

Subject: [illegible]

Reference: [illegible]

Address: [illegible]

Date: [illegible]

Printer: [illegible]

From: [illegible]

Subject: [illegible]

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DE 11 10 12

[illegible text block]



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FOR STATE  
HEALTH DEPT  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03446									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8536 Adelphi Road					d. STREET ADDRESS 8536 Adelphi Road				
3. NAME OF DECEASED (Type or print) Edna Leola JEWELL					4. DATE OF DEATH March 26th., 19 61				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1880		9. AGE (In years last birthday) 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Thomas Magaha					14. MOTHER'S MAIDEN NAME Mary E. Bales				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Vyolet J. Trittippoe, same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED March 26th. 1961				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 3/28/61		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		
23. FUNERAL DIRECTOR F. Gasch's Sons					ADDRESS Hyattsville, Md.		22d. LOCATION (City, town, or country) (State) Beallsville, Maryland		
24a. REC'D BY REGISTRAR					24b. REGISTRAR'S SIGNATURE				
DATE MAR 29 '61					ARTHUR L. KRAUS				

100-20000  
DEATH CERTIFICATE  
VI

3-25

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Thomas Brown	
Sex		Male	
Age		35	
Date of Birth		July 11, 1890	
Place of Birth		Boston, Mass.	
Usual Residence		123 Main St., Boston, Mass.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date of Examination		March 25, 1925	
Signature of Registrar		[Signature]	
Date of Registration		March 26, 1925	

may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3455

03448

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>18 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>5309 38th Ave.</b>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>G.</b> Last <b>Kandle</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-93</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Superintendent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>APT. BUILDINGS</b>			
11. BIRTHPLACE (State or foreign country) <b>CAMDEN, NEW JERSEY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-40414</b>			
17. INFORMANT Address <b>MRS RUBY KANDLE, WIFE. SAME AS #2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic epididymal carcinoma</b> 147.0 DUE TO <b>floor of mouth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary site: base of tongue</b> DUE TO (c) <b>Primary site: base of tongue</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1961</b> to <b>March 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1961</b> , and that death occurred <b>8:55 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Harry N. Carlton</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3 37 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry N. Carlton, M.D.</b>				22d. ADDRESS <b>940 25th St. Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3-30-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Forestville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>V.W. Chambers</b>				ADDRESS <b>5801 - Cleveland Ave.</b>		25a. REC'D BY REGISTRAR <b>MAR 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraser</b>							

(M)  
077  
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3455

CENTRAL STATE OF DEATH

10-1-12

Primary site: base of tongue

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please note the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bowie Race Track Dispensary</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundle</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lake Shore, Pasadena</b> d. STREET ADDRESS <b>#1 Park Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Louis Kauffman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27th.</b> Year <b>19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1894</b>	9. AGE (in years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic - Retired Refrigeration</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>August Kauffman</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Holland</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-18-4400</b>		17. INFORMANT <b>Mrs. Anita M. Samneck,</b> Address <b>#1 Park Drive Lake Shore, Pasadena, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>March 27th. 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b> 22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Md.</b>			
23. FUNERAL DIRECTOR <b>Hopping &amp; Kirkley</b> ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3457  
077

CERTIFICATE OF DEATH

03450

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b> d. STREET ADDRESS <b>7314 Forest Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ann</b> Last <b>Kennedy</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-85-1895</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N.S.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A. Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>Margaret McCarthy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ann Evelyn Kennedy</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>5 years</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1956</b> to <b>6 Mar 1961</b> , that (I) (we) last saw the deceased alive on <b>6 Mar 1961</b> , and that death occurred at <b>12-20 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas G. Maloney</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas G. Maloney</b>		22d. ADDRESS <b>4814 71 St. Avenue, Landover Hills</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews</b>		23d. LOCATION (City, town, or county) (State) <b>Roanoke, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines Co</b>		25a. REC'D BY REGISTRAR <b>2901-14 St. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>MAR 8 '61</b>	

1528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3458

CERTIFICATE OF DEATH

Reg. Dist. No.

03451

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Riverdale</u> 65	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4911 Riverdale Rd.</u>		d. STREET ADDRESS <u>4911 Riverdale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>May</u> Last <u>Kerns</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Dignan</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Slogle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>informant</u>	
17. MARYNEWMAN <u>4911 Riverdale Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Constrictive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerotic heart dis.</u> (c) <u>6 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1961</u> to <u>Mar 24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb-16</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>LW Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>3-24-61</u>	
PHYSICIAN'S NAME (Type) <u>LW Malin M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3.27.61</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Mt Olivet Presbyterian Rural</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hancock &amp; Stone</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 29 '61</u>	
ADDRESS <u>Hancock md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	



may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3459

03452

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>Green Meadows Hyattsville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>6223 20th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATIE</u> First <u>V</u> Middle <u>KESSLER</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 25, 1885</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Thomas H. Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Eutoka G. Froley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>James B Kessler Jr</u> Address <u>6223 20th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>OVER 10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-26-53</u> 19 <u>—</u> to <u>3-8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-8</u> 19 <u>61</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Israel Kessler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ISRAEL KESSLER</u>				22d. ADDRESS <u>5801-16 50th St, NW, WASH, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>				ADDRESS <u>4812 BA AVE</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

Note! PRONOUNCED DEAD BY DR. L. HAYS WHO CONTACTED POLICE  
& CORONER (DR. BOYD) & I WAS GIVEN PERMISSION TO  
SIGN CERTIFICATE.

J. Kimlin, MD



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03453											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b> d. STREET ADDRESS <b>6409 E Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARTHA REBECCA KINNAMONT</b>						4. DATE OF DEATH <b>March 7, 19 61.</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1896</b>		9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (Ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John William Brown</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Welime Hensel</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William Melvin Kinnamont,</b>		Address <b>#20 South Hudson St. Alexandria, Va.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung hemorrhage</b> <b>4213</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured pulmonary arterial</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes, Cardio Vascular Renal Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>March 7, 1961.</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Mar. 10, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D. C.</b>			
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., 517 11th St., S.E. Wash. DC.</b>						24a. REC'D BY REGISTRAR <b>MAR 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

11030

A. G. C.

1. The first group of people who are not allowed to enter the country are those who are not citizens of the United States.

1998, 2000

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1957-1958

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SECRET

Journal of the American Medical Association

1. *Thomomys talpae* (Lillj.)

At 10:30 AM

10-14-01 1-31-01

1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 26

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U. S. DEPARTMENT OF COMMERCE, BUREAU OF ECONOMIC RESEARCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
3461  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 03454

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Goe's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Valley		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5231- Ellis Street S. E.		d. STREET ADDRESS 5231- Ellis Street S.E.	
3. NAME OF DECEASED (Type or print) PATRICIA First SUE Middle KISER Last		4. DATE OF DEATH March 12th 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25- 1959
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR 11 Months 1 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard K. Kiser		14. MOTHER'S MAIDEN NAME Ruth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Howard K. Kiser Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 289.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c) Nelson . Pick disease 17 Mes		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-20-57, 19, to 3-11-61, 19, that I last saw the deceased alive on 3-11-61, 19, and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harold Y. Finck MD ADDRESS (Street, city or town, state) 1435 8th Ave Rd SE DATE SIGNED PHYSICIAN'S NAME (Type) HAROLD Y. FINCK, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14-61	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661 Good Hope Rd Washington DC		24a. REC'D BY REGISTRAR DATE MAR 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

1961

0510

1. Name of deceased: *John A. Smith*  
2. Sex: *Male*  
3. Date of birth: *10-15-1915*  
4. Place of birth: *St. Louis, Mo.*  
5. Usual residence: *1234 N. Main St., Baltimore, Md.*  
6. Cause of death: *Myocardial Infarction*  
7. Date of death: *11-10-1961*  
8. Time of death: *11:00 AM*  
9. Place of death: *Home*  
10. Signature of physician: *Dr. J. H. Jones*  
11. Signature of registrar: *John A. Smith*  
12. Signature of informant: *John A. Smith*

13. Name of funeral home: *John A. Smith*  
14. Name of cemetery: *John A. Smith*  
15. Name of burial place: *John A. Smith*  
16. Name of interment place: *John A. Smith*  
17. Name of crematorium: *John A. Smith*  
18. Name of other place: *John A. Smith*  
19. Name of other place: *John A. Smith*  
20. Name of other place: *John A. Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3462

## CERTIFICATE OF DEATH

Reg. Dist. No. 13455

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Enterprise Road &amp; Central Avenues</b>				d. STREET ADDRESS <b>Enterprise Road &amp; Central Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Manbeck</b> Last <b>Kolbe</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1961.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming (Ret.)</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles J. Kolbe</b>		14. MOTHER'S MAIDEN NAME <b>Catherine M. (nee Manbeck) Kolbe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Miss Catherine Simpson-Mitchellville, Md.</b>		17. INFORMANT <b>Miss Catherine Simpson-Mitchellville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac failure</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Myocarditis</b> DUE TO <b>Unknown</b> (c) <b>General Arterio Sclerosis</b> DUE TO <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema-Chronic Pulmonary</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)</b> <b>Natural Causes</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 15</b> , 19 <b>61</b> , to <b>March 29</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>61</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5440 Silver Hill Rd SE Washington 28 DC</b> DATE SIGNED <b>Arthur L. Kraus</b>							
ACTUAL SIGNATURE <b>Paul C Van Natta</b>		M.D. <b>5440 Silver Hill Rd SE</b>		PHYSICIAN'S NAME (Type) <b>PAUL C VAN NATTA</b>		<b>Washington 28 DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home</b>				ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



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may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3463

03456

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>West Lanham</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>4801 West Lanham Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna E. LaBossiere</b> Middle <b>LaBossiere</b> Last <b>LaBossiere</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1920</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>40</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sibley Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Providence, Rhode Island.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Providence, Rhode Island.</b>				13. FATHER'S NAME <b>John M. Quinn</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret G. Rinn</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Robert R. LaBossiere</b> Address <b>Same as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast -</b> 170X DUE TO <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 years</b> DUE TO (c) <b>4 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1958</b> to <b>3/22, 1961</b> , that (I) <b>(was)</b> lost saw the deceased alive on <b>3/12, 1961</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b> M.D.				22b. DATE SIGNED <b>3-22-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>F. E. MUSSER, MD.</b>				22d. ADDRESS <b>4410 74 Ave, Landover Hills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 27-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brockton, Mass.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>1661 Good Hope Rd. S.E. Washington, DC</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3464

## CERTIFICATE OF DEATH

Reg. Dist. No. 03457

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>5 months</b>		d. STREET ADDRESS <b>5400-Bradley Blvd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattsville Nursing Home</b> <b>5801-42nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>J.</b> Last <b>Lapp</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1887</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>22</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>ELLENVILLE, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adolph Lapp</b>		14. MOTHER'S MAIDEN NAME <b>Sarah — Lapp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. CLAUDE LAPP</b>		Address <b>5400 Bradley Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> <b>420-0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b> <b>3 weeks</b> <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 12, 1960</b> , to <b>March 10, 1961</b> , that I last saw the deceased alive on <b>March 7, 1961</b> , and that death occurred at <b>12:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6001-35th Ave. Hyattsville Md</b> DATE SIGNED <b>3/10/61</b>			
ACTUAL SIGNATURE <b>W. H. Clements</b>		M.D. <b>6001-35th Avenue, Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. H. CLEMENTS, M.D.</b>		<b>6001-35th Avenue, Hyattsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Mar. 13/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	22d. LOCATION (City, town, or county) (State) <b>WHEATON, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson</b>		24a. REC'D BY REGISTRAR <b>WASH. D.C.</b> DATE <b>MAR 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please send the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03458

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Pines</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Beacon Light Road</b>		
3. NAME OF DECEASED (Type or print) <b>Phillip Dunmore Lee</b>			4. DATE OF DEATH <b>March 8, 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 16, 1885</b>		9. AGE (In years last birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>George Phillip Lee</b>			14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Hutchinson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>377-20-8327</b>		
17. INFORMANT <b>Clifford Lee, Same as # 2</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>442X</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Washington, D.C.</b>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James I. Boyd</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>3/11/61</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>		
23. FUNERAL DIRECTOR <b>Arthur S. Stewart</b>			ADDRESS <b>30 H Street, N.E.</b>		
24a. REC'D BY REGISTRAR <b>MAR 13 1961</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Stewart</b>		

MEDICAL CERTIFICATION



STATE OF NEW YORK  
JANUARY 1901

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JANUARY 1901



may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYARD STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03459

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, DC</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>2901 Denver SE. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Reel Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Elmer Lewis Sr.</u>				4. DATE OF DEATH <u>March 30 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1889</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Moving Picture Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>		13. FATHER'S NAME <u>William M. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Effie Lee Reese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Dolly Lewis</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive Ht. Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Ht. Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of Lung &amp; Lung Abscess 1 year</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>✓</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>✓</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) <u>✓</u> (County) <u>✓</u> (State) <u>✓</u>
21. I certify that (I) (this hospital) attended the deceased from <u>December 5, 1956</u> to <u>March 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 29, 1961</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Gibson</u>				22b. DATE SIGNED <u>March 30, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>W. W. Gibson, M.D.</u>	
22d. ADDRESS <u>4340 St. Barnabas Road, 21, D.C.</u>				22e. <u>✓</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u>				25a. RECEIVED BY REGISTRAR <u>APR 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

I, the undersigned, being a duly qualified Medical Officer of Health for the District of \_\_\_\_\_, do hereby certify that \_\_\_\_\_  
 was born on \_\_\_\_\_ at \_\_\_\_\_  
 and died on \_\_\_\_\_ at \_\_\_\_\_  
 of \_\_\_\_\_  
 and that the cause of death was \_\_\_\_\_  
 and that the death was due to natural causes.  
 Witness my hand and the seal of the District of \_\_\_\_\_ at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_.  
 \_\_\_\_\_  
 Medical Officer of Health

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3467 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 18b - Film G-283 3/24/61.cac									
03460									
1. PLACE OF DEATH a. COUNTY		Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Cheverly		D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prince Georges General Hospital				d. STREET ADDRESS		34 Palmer Park	
3. NAME OF DECEASED (Type or print)		Edward		Naylor		Lurty		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		Male		6. COLOR OR RACE		White		4. DATE OF DEATH	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		May 26, 1920		March 16, 19 61.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Police Officer		10b. KIND OF BUSINESS OR INDUSTRY		U. S. Capital		9. AGE (In years last birthday)	
13. FATHER'S NAME		Edward Lurty		14. MOTHER'S MAIDEN NAME		Beaulah Naylor		11. BIRTHPLACE (State or foreign country)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give name and dates of service)		Yes		16. SOCIAL SECURITY NO.		WWII		12. CITIZEN OF WHAT COUNTRY?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 871.0 DUE TO (b) Pulmonary edema Conditions, if any, which gave rise to immediate cause (c) Acute barbiturate poisoning (e), stating the underlying cause last. Acute barbiturate poisoning		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. M.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		JAMES I. BOYD, M.D.		M.D.		March 16, 1961			
EXAMINER'S NAME (Type)		JAMES I. BOYD, M.D.		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial		3/20/61		Arlington National Cmtry.		Arlington Va.			
23. FUNERAL DIRECTOR		F. Gasch's Sons		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Hyattsville, Md.				MAR 20 '61		Arthur L. Kram			

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**MEDICAL CERTIFICATION**

22a. SIGNATURE 

22c. PHYSICIAN'S  
NAME (Type

Thomas F. Cullen

M.D.

ATTENDING  
PHYS. ☒

22d. ADDRESS

MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE  
SIGNED

23a. BURIAL, CREMATION  
REMOVAL (Specify)  
**Burial**

23b. DATE THEREOF  
March 29/61

23c. NAME OF CEMETERY OR CREMATORY  
Arlington National

23d. LOCATION (City, to  
Arlington

(State)  
Va.

24 FUNERAL DIRECTOR'S SIGNATURE

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
Lee Funeral Home 300 4 St NE  
WASH D.C.

25a. REC'D BY REGISTRAR  
DATE MAR 28 '61

25b. REGISTRAR'S SIGNATURE  
Arthur S. Kraus

**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3468

03461

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capitol Hights				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS 816 - 49th Ave									
3. NAME OF DECEASED (Type or print) Vincent L. Mattera						4. DATE OF DEATH March 24 1961									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 8 1917		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) World War II				10b. KIND OF BUSINESS OR INDUSTRY Barber				11. BIRTHPLACE (County & State, or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Emelio Mattera						14. MOTHER'S MAIDEN NAME Rose Checchia (Wife)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) World War II				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Theresa E. Mattera Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Atherosclerotic Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH Then 3 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 1957, to.....2/24....., 1961, that (I) (we) last saw the deceased alive on.....3/24.....1961, and that death occurred at.....M, from the causes and on the date stated above															
22a. SIGNATURE Thomas F. Cullen M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen						22d. ADDRESS 4400 Bowen Rd. S.E. Wash, D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 29/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington Va.					
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300 WASH DC						ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



(M)

Prince George

Capitol Heights

Vincent

White

Enelia Matters

World War II

(I)

Maryland

Capitol Heights

816 - 43rd Ave

Matters

Dec 8 1917

Washington D.C.

Rose Chesconin

Mrs Theresa E. Matters

Prince George

March 24

43

U.S.A.

(Wife)

4400 Bowen Rd. S.E. Wash. D.C.

Enelia Matters 3061 Arlington W. Daniel

Enelia Matters 3061 Arlington W. Daniel



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3469

CERTIFICATE OF DEATH

Reg. Dist. No. 03462

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b> c. LENGTH OF STAY IN 1b <b>15 mos.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Bells Nursing for Children</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Allegheny</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monroeville</b> d. STREET ADDRESS <b>15 Valerie Circle</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jeffery Allen McCutchion</b> First Middle Last		4. DATE OF DEATH <b>March 20 1961</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Nov. 1959</b>
9. AGE (In years last birthday) <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Rugh</b>		14. MOTHER'S MAIDEN NAME <b>Carole McCutchion</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nursing Home Record (Bell's)</b>		Address <b>Same as # 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus (internal)</b> 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Spinafida</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>birth on</b> <b>birth on</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/30</b> , 19 <b>60</b> , to <b>3/20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3/20</b> , 19 <b>61</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6905 Ball Rd 3/21/61</b> ACTUAL SIGNATURE <b>Thomas A. Christensen</b> M.D. PHYSICIAN'S NAME (Type) <b>Thomas A Christensen</b> <b>College Park Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>22 Mar. 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>MAR 29 61</b>	
ADDRESS <b>Hyattsville, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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John Doe

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John Doe, born [illegible]

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John Doe, born [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Medical Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 20 Film 284 4-14-61											
Phone call from F. D. St.											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>South Chevrly, Forest, Md.</b>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <b>3506- 56th Ave.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John Patrick Mc Ginnis</b>						4. DATE OF DEATH <b>March 5th 1961</b> 19					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/13/55</b>		9. AGE (In years last birthday) <b>5</b> yrs. <b>6</b> Months <b>20</b> Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Francis Mc Ginnis</b>						14. MOTHER'S MAIDEN NAME <b>Mary Stella Mc Ginnis nee Jones</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>John Patrick Joseph Francis Mc Ginnis</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusion of the spinal cord</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Distraction of the first and second cervical vertebrae</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was playing at home and slipped and fell down a terrace about 6 feet high turning a somersault.</b>							
20c. TIME OF INJURY Month, Day, Year <b>5/10 p.m. 3/5/61</b> 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>yard of home</b>			
20f. (City or town) <b>South Cheverly Forest, P.G.Co.Md</b>				(County)				(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd D.M.E.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>James I. Boyd D.M.E.</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <b>3/5/61</b>					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/7/61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			
22d. LOCATION (City, town, or country) <b>Washington, D.C.</b>				(State) <b>Md.</b>							
23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						24a. REC'D BY REGISTRAR <b>Hyattsville, MdX</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

MEDICAL CERTIFICATION

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Washington, D.C., U.S.A.

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*(Faint bleed-through from the reverse side of the page)*

James T. V. L.

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may be filled by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3471

03464

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nottingham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Nottingham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>belia</u> First <u>middleten</u> Middle <u>1</u> Last				4. DATE OF DEATH <u>march</u> Month <u>13</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1896</u>		9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henson Dyson</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Duckett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clarence Middleten-Nottingham</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420D</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Heavy Cerebral and Renal Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> 19 <u>58</u> to <u>3-13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-13</u> 19 <u>61</u> , and that death occurred at <u>P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				22d. ADDRESS <u>Brandywine, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooks M.E.</u>		23d. LOCATION (City, town, or county) (State) <u>Nottingham, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Nelson Aguasco, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 17 61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

M

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VS. A15ME  
5M 7/59



2173

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1931

Place: George County  
Twp: 1  
Sec: 3  
Range: 1  
County: George  
State: Georgia  
Date: Jan 18, 1931  
Time: 10:00 AM

Age: 45  
Sex: Male  
Race: White  
Occupation: Farmer  
Cause of Death: Heart Disease  
Manner of Death: Natural

Signature: Dr. J. W. Smith  
Address: 123 Main St, Macon, Ga  
Date: Jan 18, 1931

Witness: John Doe  
Address: 456 Oak St, Macon, Ga  
Date: Jan 18, 1931

Signature: John Doe  
Address: 456 Oak St, Macon, Ga  
Date: Jan 18, 1931

Signature: John Doe  
Address: 456 Oak St, Macon, Ga  
Date: Jan 18, 1931

Signature: John Doe  
Address: 456 Oak St, Macon, Ga  
Date: Jan 18, 1931

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03466	
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 1 6201 New York Place					
3. NAME OF DECEASED (Type or print) SARAH						4. DATE OF DEATH Month March Day 18 Year 19 61.					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1906		9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Natoli						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph Natoli, same as # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 ACUTE CONGESTIVE HEART FAILURE DUE TO (b) PENDING Myocarditis DUE TO (c) Focal occlusion atherosclerosis of coronaries										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE JAMES I. BOYD, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						DATE SIGNED March 18, 1961.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				22b. DATE THEREOF 3/22/61		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				22d. LOCATION (City, town, or country) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,						ADDRESS Riverdale, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

ON 21st  
HEALTH UNIT

M

1

Prince Georges County  
Maryland  
Baltimore

Prince Georges General Hospital  
and New York Roads  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

Joseph Lincoln, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

James I. Dole, M.D.  
Baltimore  
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3474

CERTIFICATE OF DEATH

Reg. Dist. No.

03467

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 325 Swan Road		d. STREET ADDRESS 325 Swan Road	
3. NAME OF DECEASED (Type or print) First JACK Middle C. Last NORRIS		4. DATE OF DEATH Month March 13th, Day Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7th, 1871
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer--Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Tenn.
13. FATHER'S NAME Charley Norris		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Ruby L. Key, 325 Swan Road, Suitland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Route Congestive Cardiac Failure DUE TO (b) Cardiovascular Renal Disease DUE TO (c) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note			INTERVAL BETWEEN ONSET AND DEATH 12 hrs unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Cause	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 2, 1961, to March 13, 1961, that I last saw the deceased alive on March 13, 1961, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Paul C. Van Natta M.D.		5440 Silver Hill Rd DE	
PHYSICIAN'S NAME (Type) PAUL C VAN Natta		Washington 28 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/17/1961	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Chattanooga, Tenn.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE MAR 15 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus



155



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10-5-61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3475

## CERTIFICATE OF DEATH

Items 2c, d & 4

File G284 4/5/61 1wk

03468

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanivel</u>		c. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Lanivel</u>	
c. LENGTH OF STAY IN 1b <u>111 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1031 Turney St Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gerald Stuart O'Connor</u>		4. DATE OF DEATH Month Day Year <u>March 23 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice Albert O'Connor Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sara Louella Beard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Suzanne O'Connor Welch Wilson Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7 1959</u> to <u>3/23 1961</u> , that (I) (we) last saw the deceased alive on <u>3/23 1961</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert S. McCaney</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert S. McCaney, M.D.</u>		22d. ADDRESS <u>402 Main St, Lanivel Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial March 27, 1961</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>He Witt Donaldson</u>		25a. REC'D BY REGISTRAR <u>Mar 29 '61</u>	
ADDRESS <u>Lanivel Md</u>		25b. REGISTRAR'S SIGNATURE	

0300

RECEIVED  
JANUARY 10 1941

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please complete the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3476 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03469

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>XXXXX College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>5032 Branchville Road</b>			
3. NAME OF DECEASED (Type or print) <b>Louis Frank Ombres Sr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27th.</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1890</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>61</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1 175-03-6939</b>		17. INFORMANT <b>Mrs Angelia Ombres, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 30, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.</b>				24. READ BY REGISTRAR <b>Riverdale, Maryland.</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>			

DATE  
MAR 29 '61

RECEIVED  
JAN 10 1901

(M)

James J. Smith  
Director

James J. Smith

James J. Smith

James J. Smith

James J. Smith

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James J. Smith

James J. Smith

James J. Smith

# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>Transient</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>4524 - 32nd. Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret</b> <b>Female</b> <b>Caucasian</b>		4. DATE OF DEATH <b>March 27th, 1961</b>		9. AGE (in years last birthday) <b>93</b> yrs.	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Charles W. Gordon</b>		14. MOTHER'S MAIDEN NAME <b>Frances Weedon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>4422 X</b>		17. INFORMANT <b>Halter, B. Magruder, Sr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4422 X</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20d. (City or town) <b>Prince George's</b>		20e. (County) <b>Prince George's</b>		20f. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 27th., 1961</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
22d. LOCATION (City, town, or country) <b>Switzland, Md.</b>		22e. ADDRESS <b>Mt. Rainier</b>		22f. REC'D BY REGISTRAR <b>APR 3 '61</b>	
23. FUNERAL DIRECTOR <b>Nalley's Funeral Home</b>		23a. ADDRESS <b>101 Mt. Rainier</b>		23b. REGISTRAR'S SIGNATURE <b>James I. Boyd</b>	

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

James Gordon

James Gordon

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James Gordon



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3478

03471

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b> c. LENGTH OF STAY IN lb <b>9. Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b> d. STREET ADDRESS <b>17. BlackHawk. Dr</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Glenn F Ostwalt</b>			4. DATE OF DEATH <b>March. 25. 19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.26.1901</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Const.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N. Carolina</b>	
13. FATHER'S NAME <b>Jefferson Davis.Ostwalt</b>			14. MOTHER'S MAIDEN NAME <b>Rosa Little</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES 1941-1945</b>			16. SOCIAL SECURITY NO. <b>226.03.4465</b>		
17. INFORMANT <b>Voda. A. Ostwalt</b>			17. Address <b>#17. Blackhawk. Dr Forest Heights. Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Arterio sclerotic heart disease</b> DUE TO (c) <b>Hypercholesterolemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>3/14 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (H) (this hospital) attended the deceased from <b>3/14 1961</b> , to <b>3/25/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/25/61</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. Etienne Szollosi</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. ETIENNE SZOLLOSI</b>		22d. ADDRESS <b>2 PARKWAY Drive Forest Hgts. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3.28.61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethlehem Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Statesville. N. Carolina</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home. 300.4th st N E. Wash</b>		ADDRESS <b>D C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 28 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>

VR A15 (4)  
15M 9/60

(M)

0428

OFFICE OF DEATH

Prince George Maryland Prince George

Forest Heights 9. 170  
17. Blackhawk Dr. Forest Heights

Male White Glenn  
2. 26. 1901 Oswalt March. 23. 01

Net Const. Building  
Jefferson Davis. Oswalt  
A. Carolina Rosa Little

17. Hinchew. Dr. 17. Hinchew. Dr.  
Forest Heights. 17. Hinchew. Dr.

(1)

Funeral Home. 300. 4th St. N. Wash.  
Bethlehem Cemetery Statesville. N. Carolina  
Burial 3. 8. 01

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3479

## CERTIFICATE OF DEATH

Reg. Dist. 03472

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route #2 Accokeek, M.D.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Chapel Hill, MD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jeanette</b> Middle <b>Parker</b> Last <b>Parker</b>		4. DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-1888</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>3</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham King</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Dyson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO <b>Arteriosclerotic cardiac disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cardiac decompensation</b> (b) <b>Cardiac decompensation</b> (c) <b>Cardiac decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>2 years</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lues</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 18, 19 59</b> to <b>March 3, 19 61</b> , that I last saw the deceased alive on <b>March 3, 19 61</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Accokeek</b> DATE SIGNED	
ACTUAL SIGNATURE <b>Paul Chen</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Paul Chen, M. D.</b>		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-7-61</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pomonkey, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b> ADDRESS <b>3017 28th St. W. Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ACCORDING TO RECORDS OF THE  
DEPARTMENT OF HEALTH  
AND THE RECORDS OF THE  
DEPARTMENT OF VETERANS AFFAIRS  
THE FOLLOWING INFORMATION IS  
HEREBY FURNISHED:

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. DATE OF DEATH <b>10-10-1918</b>	
3. PLACE OF DEATH <b>HOME</b>		4. CAUSE OF DEATH <b>HEART DISEASE</b>	
5. SEX <b>MALE</b>		6. AGE <b>45</b>	
7. OCCUPATION <b>LABORER</b>		8. BIRTH DATE <b>1873</b>	
9. BIRTH PLACE <b>MASSACHUSETTS</b>		10. MARRIAGE DATE <b>1895</b>	
11. NAME OF SPOUSE <b>MARY J. BROWN</b>		12. NAME OF CHILDREN <b>JOHN J. BROWN JR.</b>	
13. NAME OF NEXT OF KIN <b>MARY J. BROWN</b>		14. NAME OF MINISTER <b>PASTOR J. J. BROWN</b>	
15. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>		16. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>	
17. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>		18. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>	
19. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>		20. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>	
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97. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>		98. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>	
99. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>		100. NAME OF BURIAL PLACE <b>CATHOLIC CHURCH</b>	

CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03473

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6723 Roosevelt Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louise Rosalie Parks				4. DATE OF DEATH March 27th., 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Gift Shop				10b. KIND OF BUSINESS OR INDUSTRY Gift Shop		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fabian A. Augustine				14. MOTHER'S MAIDEN NAME Mary L. LeBhret			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Francis G. Augustine, Wash., D.C.		Address 3610 26th St., N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE SUBARACHNOID HEMORRHAGE 330X DUE TO (b) RUPTURED ANEURYSM, Ant. cerebral ARTERY Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED March 27, 1961			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) XXXXXX				22b. DATE THEREOF 3-30-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
				22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR J.Wm. Lee's Sons Co. 300-4th St. N.E.				24a. REC'D BY REGISTRAR APR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3481

Item 9 Film G263 3/30/61 mh

03474

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. DC.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 LaSalle Rd.</u>		d. STREET ADDRESS <u>1705 P. St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Pettit</u> Last <u>Pettit</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-79</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Printing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Pettit</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Kennan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. M. Bernadette Joseph</u>		Address <u>Hyattsville Md. 4922 La Salle Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal hemorrhage from</u> <u>572.1</u> DUE TO <u>Chronic colitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dyspepticulitis</u> DUE TO (c) <u>50 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 15</u> 19 <u>61</u> to <u>Mar 22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 22</u> 19 <u>61</u> , and that death occurred at <u>9:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.		22b. DATE SIGNED <u>3/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>		22d. ADDRESS <u>1511-17 ST. N.W. WASH. DC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '61</u> DATE	
ADDRESS <u>3821-14th St. N.W. Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

STATE OF TEXAS  
COUNTY OF DALLAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G283 3/20/61 iwk											
03475											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> c. LENGTH OF STAY IN 1b <b>—</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chew Road, Upper Marlboro.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 3139, Chew Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>RICHARD</b>			First <b>Berman</b>		Middle <b>PINKNEY</b>		Last <b>PINKNEY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11,</b> Year <b>19 61.</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1913</b>		9. AGE (In years last birthday) <b>46 47</b>		IF UNDER 1 YEAR Months <b>47</b> Days <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Prince Geo. Cty.</b>		11. BIRTHPLACE (State or foreign country) <b>Nottingham, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George A. Pinkney</b>					14. MOTHER'S MAIDEN NAME <b>Lena Skinner</b>					Address <b>Box 3139 Chew Road</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Mary Louise Pinkney,</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Shot gun wound of the abdomen</b> DUE TO (c) <b>919.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.) <b>Injured by the accidental discharge of a shot gun</b>							
20c. TIME OF INJURY Month, Day, Year <b>1:15</b> Hour <b>3/11</b> p.m. <b>19 61</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Yard of home</b>		20f. (City or town) <b>Upper Marlboro P.G.</b>		20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				JAMES I. BOYD, M.D.				DATE SIGNED <b>March 11, 1961.</b>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county) <b>March 11, 1961.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>3/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CHURCH CEM.</b>		22d. LOCATION (City, town, or country) (State) <b>NAYLOR, MARYLAND</b>			
23. FUNERAL DIRECTOR <b>McGuire Funeral Service</b>						24a. REC'D BY REGISTRAR <b>DATE MAR 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

1965, 11 April

W. H. COT. I BELIEVE

3483

CERTIFICATE OF DEATH

Reg. Dist. No. 03476

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley, Md.</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sara E. Power</i>		4. DATE OF DEATH <i>3-25-1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/3/1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>never worked</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Middletown Conn.</i>
13. FATHER'S NAME <i>John J. Power</i>		14. MOTHER'S MAIDEN NAME <i>Mary J. Ward</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.0 DUE TO <i>Coronary-Sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-6-1955</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Fibrillation</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <i>James A.O. Keetle</i> attended the deceased from <i>11/4/57</i> , 19___, to <i>3/25/65</i> , 19___, that I lost saw the deceased alive on <i>3/18/61</i> , 19___, and that death occurred at <i>M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James A.O. Keetle</i> M.D.		ADDRESS (Street, city or town, state) <i>4501-Corn. near W.C. Ave.</i> DATE SIGNED <i>Apr. 15</i>	
PHYSICIAN'S NAME (Type) <i>James A.O. Keetle MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-7-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home Inc.</i>		24a. REC'D BY REGISTRAR <i>—</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

CERTIFICATE OF DEATH

3483

1917

State of New York  
County of New York  
City of New York  
I, the undersigned, being a duly qualified medical officer of health, do hereby certify that  
the within and foregoing is a true and correct copy of the original record of the death of  
the person named therein, as the same appears from the files of the Bureau of Vital Statistics,  
in accordance with the provisions of the laws of the State of New York.  
Witness my hand and the seal of the Department of Health, at Albany, New York,  
this \_\_\_\_\_ day of \_\_\_\_\_, 1917.  
\_\_\_\_\_  
Medical Officer of Health



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03477									
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1831 9th Street N. W.				
3. NAME OF DECEASED (Type or print) HARRY PRICE					4. DATE OF DEATH March 18, 19 61.				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1924		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME George Drakford					14. MOTHER'S MAIDEN NAME Carry Price				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11					17. INFORMANT Address Mrs Carry P. Jackson, same as # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE AND SHOCK DUE TO STAB WOUND OF CHEST Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during an altercation				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30 x 3/18/61					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> el work <input type="checkbox"/> el work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a gas station					20f. (City or town) Glen Arden Woods, P. G., Md. (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) March 18, 1961.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va			
23. FUNERAL DIRECTOR Johnson & Jenkins 4804 Garfield Ave					24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAR 22 '61 Arthur S. Thomas				

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Division of Columbia

Washington

E.O. 12812

Secretary

James O. Eastland

1951 and 1952

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August 22, 1952

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U. S. A.

John L. Lewis

General

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
(M)

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt c. LENGTH OF STAY IN 1b 1 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 Fayette Place												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 5 Fayette Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Jones Quisenberry 4. DATE OF DEATH March 20th. 1961																							
5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 24th. 1896 9. AGE (In years last birthday) 64 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.																							
13. FATHER'S NAME Henry Broadus 14. MOTHER'S MAIDEN NAME Anna L. McIntire 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT James R. Quisenberry Same as #2																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) Diabetes of 35 years duration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 20th. 1961 EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. Address (Street, city, town, or county)																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF March 22, 1961 22c. NAME OF CEMETERY OR CREMATORY Antioch Baptist Ch. Ceme. 22d. LOCATION (City, town, or country) (State) St. Just, Virginia																							
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., ADDRESS Riverdale, Maryland. 24a. REC'D BY REGISTRAR MAR 23 61 24b. REGISTRAR'S SIGNATURE																							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3486

## CERTIFICATE OF DEATH

03479

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>11 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6911 Barton Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Tony</b>			4. DATE OF DEATH <b>Mar. 10 1961</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Apr. 22, 1902</b>		
9. AGE (In years last birthday) <b>58 yrs.</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>United States Air Force</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Portugal</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Anna ?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>WW 11 220 34 4968</b>		
17. INFORMANT <b>Hildegard Ramos</b>			Address <b>Hyattsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis with Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertension with AS of heart</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 1957</b> to <b>3/10/61</b> that (I) (we) last saw the deceased alive on <b>3/9/61</b> and that death occurred at <b>4:25 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. F.E. Musser, M.D.</b>			22b. DATE <b>3-10-61</b>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <b>4410 74th Ave Bellemead, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/14/61</b>		
23c. NAME OF CEMETERY OR <del>CHURCH</del> <b>Arlington National</b>			23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. Gasch's Sons Hyattsville Md.</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 16 '61</b>		
			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		

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**KEY WORDS:** aging; depression; health status; life expectancy

\* U.S. DEPARTMENT OF AGRICULTURE \*  
\* OFFICE OF THE SECRETARY \*  
\* WASHINGTON, D.C. 20250 \*

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FOR STATE  
HEALTH DEPT  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1740 40th Street S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GARNETT LATNE REAMY</b>		4. DATE OF DEATH Month Day Year <b>MARCH 13, 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Oscar Lee Remy</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Bowler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-12-3336</b>	
17. INFORMANT <b>Reamy</b>		Address <b>Mrs Elizabeth R. Remy, Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Crushed chest, multiple lacerations of the face</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>In an automobile that was in an head on collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:20 3/13/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Silver Hill P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>MARCH 13, 1961</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVED</b>		22b. DATE THEREOF <b>3-16-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Singers Glen, Va.</b>		22d. LOCATION (City, town, or country) (State) <b>Singers Glen, Va.</b>	
23. FUNERAL DIRECTOR <b>J.Wm. Lee's Sons Co</b>		ADDRESS <b>300-4th St N.E. Wash, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAR 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	

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UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Pages 1 and 2 should be filed with

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 1521 Kanawha Street	
3. NAME OF DECEASED (Type or print) First Karen Middle Louise Last Reilly		4. DATE OF DEATH Month March Day 29 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Mar 1961
9. AGE (In years last birthday) 15 days		10. IF UNDER 1 YEAR Months 15 Days 15 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cheverly Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert J. Reilly		14. MOTHER'S MAIDEN NAME Theresa C. Plummer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & dehydration (E.COR 086+0127) 4 days 764.5 DUE TO (b) Inanition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) life PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURETY + ATELECTASIA 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24 1961 to 3/29 1961, that (I) (we) last saw the deceased alive on 3/29 1961, and that death occurred at 6:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph McDonald M.D.		22b. DATE SIGNED 3/29/61	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph McDonald M.D.		22d. ADDRESS 7309 RIGGS RD. HATTESVILLE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Int. Olevet Cemetery		23d. LOCATION (City, town, or county) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS mt. Rainier md.	
25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE William S. Kinn	

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REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

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THE COMMISSIONER OF THE LAND OFFICE  
HONORABLE THE GOVERNOR  
ALBANY, N. Y.  
JANUARY 1, 1901

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
FOR THE YEAR 1899

ALBANY, N. Y.  
JANUARY 1, 1901

PRINTED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
AT ALBANY

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3489

## CERTIFICATE OF DEATH

03482

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>1521 Kanawha Street</b>			
3. NAME OF DECEASED (Type or print) <b>Kenneth Patrick Reilly</b>				4. DATE OF DEATH <b>15 March 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>Boy</b>		8. DATE OF BIRTH <b>14 March 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>1</b> yrs.		11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, Maryland</b>	
13. FATHER'S NAME <b>Robert Jos.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Robert G. Reilly</b>				16. SOCIAL SECURITY NO. <b>Theresa C Plummer</b>			
17. INFORMANT <b>Robert G. Reilly</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATELECTASIS, FOETAL TYPE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>LIFE</b>			
7625 DUE TO (b) <b>PREMATURITY</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>61</b> , to <b>3/15</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>61</b> , and that death occurred at <b>9:40</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph J. McDonald</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. McDONALD</b>				22d. ADDRESS <b>7309 RIGGS RD, HYATTS, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery Wash. D.C.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley Funeral Home, Inc.</b>				ADDRESS <b>Mt. Rainier</b>		25. REC'D BY REGISTRAR <b>DATE MAR 20 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death certificate is not executed within 24 hours after death, it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
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MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03483

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Colmar Manor		d. STREET ADDRESS 3411 39th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES VAN BRACHEL RILEY				4. DATE OF DEATH Month Day Year March 29, 19 61.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1887	
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew J. Riley				14. MOTHER'S MAIDEN NAME Emma Lloyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. 578-10-0159		17. INFORMANT Mrs. Margaret M. Riley,		Address 3411 39th Avenue Colmar Manor, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				Address (Street, city, town, or county) March 29, 1961.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/61		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Maryland.				24a. REC'D BY REGISTRAR APR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

THE STATE  
DEPARTMENT

2390

Private George G. Gentry

Colonel Henry

U.S.A.

2nd South Maine

Private George Gentry

Henry

THE MURDER

Dec. 12, 1917

White

Industry

1 on board, 1st

from Lloyd

Andrew J. Hilly

182-10-0150 Mr. Howard J. Hilly, Col. 1st Regt. N.Y.

Home

Local confidential agent

Confidential agent

W. J. Hilly, N. Y.

Confidential Secretary

Initial N.Y. 101

Confidential Secretary

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3491

## CERTIFICATE OF DEATH

Reg. Dist. No. 13484

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>MONTGOMERY</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write full name of town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1517-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3304 LANCER DR. Ferrina Nursing Home</b>		d. STREET ADDRESS <b>8008 GARLAND AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>DARYL RAY ROBBINS</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>LEROY ROBBINS</b>		14. MOTHER'S MAIDEN NAME <b>RUTH M. WALLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>FATHER</b> Address <b>same</b>		AS # <b>2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>752X</b> DUE TO <b>INANITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydrocephalus</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/26</b> , 19 <b>61</b> , to <b>3/28</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3/28</b> , 19 <b>61</b> , and that death occurred at <b>4:10</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph McDonald</b> M.D.		DATE SIGNED <b>7309 Road B. Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Joseph McDonald</b>		<b>Hyattsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/61</b>	
22c. NAME OF CEMETERY OR <del>INTERMENT</del> <b>George Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Garco's Funeral Home</b> ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2075221XV4

CERTIFICATE OF DEATH

5101

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR A LICENSED NURSE. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3492

CERTIFICATE OF DEATH

03486

Items 13, & 14

inform. form birth certificate 3/28/61 iwk

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jeanne Patricia Rossiter</b>		4. DATE OF DEATH Month Day Year <b>March 27 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 March 1961</b>
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis John Rossiter</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Gene Rinck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/16 1961</b> to <b>3/27/ 1961</b> , that (I) (we) last saw the deceased alive on <b>3/26 1961</b> , and that death occurred at <b>1:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. F. Musser., M.D.</b>		22b. DATE SIGNED <b>3/27/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>4410 - 74th Ave. Bellemead., Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b>		25a. REC'D BY REGISTRAR <b>300 4th ST NW</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraya</b>		DATE <b>MAR 28 '61</b>	

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Washington, D.C.

Office of

April 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3493

CERTIFICATE OF DEATH

Item 12 File 6284 4/10/61 1wk

03487

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8306-14th Ave -		d. STREET ADDRESS 8306-14th Ave - 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANTONETTE Middle Russo Last		4. DATE OF DEATH Month March - 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 12 1884
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Available		14. MOTHER'S MAIDEN NAME Not Available	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Rose La Scala (same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 21 1961, to Mar 26 1961, that (I) (we) last saw the deceased alive on Mar 26 1961, and that death occurred at 1245 PM, from the causes and on the date stated above.			
22a. SIGNATURE Richard F. Shaw		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD F. SHAW		22d. ADDRESS 1524 Mich. Ave. NE WASH. 17 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 29 - 1961	
23c. NAME OF CEMETERY OR CREMATORY Olney Branch Cemetery		23d. LOCATION (City, town, or county) Portsmouth Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Watters		25a. RECEIVED BY REGISTRAR DATE MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03488

3494

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Lanham</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>1 9016 3rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Howard J</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>61</b>		5. RYON <b>Ryon</b>			
6. SEX <b>Male</b>	7. COLOR OR RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>22 Feb. 1905 56 yrs.</b>		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>18</b> Hours <b>61</b> Min.		11. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Co</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>Pearl, ?</b>					
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Pearl, ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>Yes WW # 1</b>				16. SOCIAL SECURITY NO. <b>577.07.7965</b>				17. INFORMANT <b>Mrs Alice Osborn</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO (b) <b>with metastasis to</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Cerebellum</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-17-61</b> to <b>3-18-61</b> , that (I) (we) last saw the deceased alive on <b>3-17-61</b> , and that death occurred at <b>1, 15AM</b> from the causes and on the date stated above.								22b. DATE SIGNED <b>3-18-61</b>	
22a. SIGNATURE <b>Dayton O. Watkins</b>				22c. PHYSICIAN'S NAME (Type) <b>DAYTON O. WATKINS</b>				22d. ADDRESS <b>5318 Annapolis Rd Bladensburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3.21.61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington. Va</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. L. 300 4th St. N.E.</b>				25a. REC'D BY REGISTRAR <b>MAR 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3495

CERTIFICATE OF DEATH

Reg. Dist. No. 03489

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capital Heights, Md</b>				c. LENGTH OF STAY IN 1b <b>9 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6104 D Street,.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>ALICE</b> Middle <b>SCOPIN</b> Last				4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1905</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.		11. IF UNDER 24 HRS. Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Robert W Rivenbark</b>				14. MOTHER'S MAIDEN NAME <b>Mary Giddeons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Joseph Scopin</b>				Address <b>Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>151 X</b> IMMEDIATE CAUSE (a) <b>CANCER OF STOMACH</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>November, 1959</b> to <b>March 1, 1961</b> , that I last saw the deceased alive on <b>2/28</b> , 19 <b>61</b> , and that death occurred at <b>3:30</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R.C. Kirchner</b>				ADDRESS (Street, city or town, state) <b>6480 N. H. Ave. Takoma Park Md.</b>			
PHYSICIAN'S NAME (Type) <b>R.C. KIRCHNER</b>				DATE SIGNED <b>3-1-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>			
24a. REC'D BY REGISTRAR <b>APR 2 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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U.S. DEPARTMENT OF JUSTICE

Attorney General's Office

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03490											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>D.O.A</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hosp.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>315 C St. N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Joseph Milburn Simms Jr.</b>		4. DATE OF DEATH Last <b>March</b> Month <b>7</b> Day <b>1961</b> Year		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1908</b>	
9. AGE (In years last birthday) <b>52</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Short Order Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurants</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Joseph M. Simms</b>	
14. MOTHER'S MAIDEN NAME <b>Mary B. Simms</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578*05-8904</b>		17. INFORMANT <b>William F. Hayre Jr.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO 812X Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of the skull, crushed abdomen</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pedestrian struck by a truck</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by a truck</b>									
20c. TIME OF INJURY Month, Day, Year <b>0:05 XXXX p.m. 3/ 6 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 301 Hall P. G. Md.</b>		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE THEREOF <b>3.10.61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet, Cemetery</b>		22c. LOCATION (City, town, or country) (State) <b>Washington. D C.</b>		23. FUNERAL DIRECTOR <b>Lee. Funeral Home 300.4th st N E.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

3/7/61

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03491

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>70</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College park</b> d. STREET ADDRESS <b>5005 Lakeland Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Smith</b> , Middle <b>Baby</b> , Last <b>Girl</b>				4. DATE OF DEATH Month <b>March</b> , Day <b>28</b> , Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1961</b>	
9. AGE (In years last birthday) <b>20</b>		10. IF UNDER 1 YEAR Months <b>45</b>		11. IF UNDER 24 HRS. Hours <b>20</b> , Minutes <b>45</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Gloria J. Christian</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurely</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 27, 1961</b> to <b>March 28, 1961</b> that (I) (we) last saw the deceased alive on <b>March 28, 1961</b> , and that death occurred at <b>6:25 p.m.</b> the causes and on the date stated above.							
22a. SIGNATURE <b>John W. Perkins</b>				22b. DATE <b>3/29/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. John Perkins, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>3/31/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. Gen. Hospital</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HARRY W. PENN</b>				25a. REC'D BY REGISTRAR <b>APR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	

CERTIFICATE OF DEATH

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State of New York, County of ...

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1. The purpose of this document is to provide a summary of the information received from the source regarding the activities of the group in the area of [redacted] and [redacted].

2. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

3. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

4. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

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9. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

10. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].



## CERTIFICATE OF DEATH

Reg. Dist. No.

03493

3499

1. PLACE OF DEATH a. COUNTY <b>Prince Geo's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN lb <b>2 1/2 Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suitland Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Plummer</b> Middle <b>Elisha</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1879</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bd. of Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Henry Smith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>#578-22-08-39</b>	
17. INFORMANT <b>Mary Elizabeth Smith</b>		Address <b>Upper Marlboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis (1-5-61)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1961</b> , to <b>March 30, 1961</b> , that I last saw the deceased alive on <b>March 29, 1961</b> , and that death occurred at <b>1:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. Cleary</b>		ADDRESS (Street, city or town, state) <b>5558 Silver Hill Rd SE Washington 28, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. Cleary, M. D.</b>		DATE SIGNED <b>4-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur J. [Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

(M)

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CERTIFICATE OF DEATH

MAINTAINED BY THE DEPARTMENT OF HEALTH - BOSTON, 1913

1913

Blank form with faint lines and text, including a large handwritten signature in the center.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3500

## CERTIFICATE OF DEATH

03494

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Michigan Park Hills</b> c. LENGTH OF STAY IN 1b <b>1513 Jonathan Street</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1513 Jonathan Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Michigan Park Hills</b> d. STREET ADDRESS <b>1513 Jonathan Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ROSE</b> Middle <b>CAROLINE</b> Last <b>SMITH</b>				<b>4. DATE OF DEATH</b> <b>March 19, 1961</b> Month Year			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>2/16/89</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Government</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Washington, D.C.</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.A.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>John H. Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lena Reckeweg</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>?</b>		<b>17. INFORMANT</b> Address <b>Lilian Smith same as #2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Cancer of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (the hospital) attended the deceased from <b>Sept. 13, 1960</b> to <b>Jan. 18, 1961</b> that (I) <del>not</del> saw the deceased alive on <b>Dec. 19, 1960</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Richard H. Stire</b> M.D.				<b>22b. DATE</b> <b>March 19 1961</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>RICHARD H. STIRE</b>				<b>22d. ADDRESS</b> <b>4600 CONN AVE N.W.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>23b. DATE THEREOF</b> <b>3/22/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. Washington 9, D.C.</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>MAR 21 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
 15M 9/60

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11-1012

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11-1012

11-1012

11-1012

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. The certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>						c. LENGTH OF STAY IN 1b <b>D.O.A.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Samuel Smith</b>						4. DATE OF DEATH <b>March 3, 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 23, 1903</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Murkirk, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Smith</b>						14. MOTHER'S MAIDEN NAME <b>Keziah Brewer</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eleanor Garrett,</b>		Address <b>Murkirk, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured Skull, Crushed Chest</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by an automobile</b>							
20c. TIME OF INJURY Month, Day, Year <b>7:25 a.m. 3-3 1961</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Route #1</b>			
				20f. (City or town) <b>Murkirk</b>				(County) <b>P.G.</b> (State) <b>Maryland</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <b>March 4, 1961</b>					
						Address (Street, city, town, or county)					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>3-8-61</b>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <b>Queens Chapel</b>			
								22d. LOCATION (City, town, or country) (State) <b>Murkirk Md</b>			
23. FUNERAL DIRECTOR <b>Henry S. Washington</b>						24a. REC'D BY REGISTRAR <b>Mar 8 '61</b>					
ADDRESS <b>Sr 4925 Dean Ave</b>						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

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Copyright © 1997

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may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3502

03496

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>35 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>63</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>4317 Madison Street.</b> <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>B.</b> Last <b>Smoot</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 9, about 80</b>	
9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Margaret A. O'Meara</b> Address <b>6589 Allegheny av, Sockoma Ph. Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> <b>Arterio sclerotic heart disease</b> DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>2 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-5-60</b> 19 <b>Mar. 29</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 29</b> 19 <b>61</b> , and that death occurred at <b>2:43 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John P. Clum</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-30-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John P. Clum, M.D.</b>				22d. ADDRESS <b>6110 35th Ave. Hyattsville. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3-31-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>				25a. REC'D BY REGISTRAR DATE <b>Mar 30 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

IN SENATE  
 January 11, 1901  
 REPORT  
 OF THE  
 SECRETARY OF THE INTERIOR  
 CONCERNING THE  
 LANDS BELONGING TO THE  
 UNITED STATES

OF THE  
 PUBLIC LANDS  
 OF THE  
 UNITED STATES  
 IN RESPONSE TO A  
 RESOLUTION PASSED  
 BY THE SENATE  
 MAY 10, 1899  
 CONCERNING THE  
 LANDS BELONGING TO THE  
 UNITED STATES  
 IN THE TERRITORY OF  
 ARIZONA  
 BY  
 J. M. SMITH  
 SECRETARY OF THE INTERIOR

WASHINGTON:  
 GOVERNMENT PRINTING OFFICE:  
 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3503

03497

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> <u>74</u> d. STREET ADDRESS <u>10610 Worcester</u> <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Minnie</u> First Middle Last <u>V. SOPER</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 10 1961</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-19-1891</u> <u>69</u> yrs.		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Telephone operator</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>	
<b>13. FATHER'S NAME</b> <u>Alfred Lanham</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Kidwell</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>none</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>William L Soper</u> <u>Beltsville, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Pericarditis</u> (c) <u>General ized Arteriosclerosis</u> <u>Severe Anemia</u>														<b>INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of Injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-25</u> , 19 <u>61</u> , to <u>3-10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>61</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <u>Jeanne C. Bateman M.D.</u> <b>M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3 10 61</u>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Jean C. Bateman, M.D.</u>				<b>22d. ADDRESS</b> <u>940 25th St., N.W. Washington 7, D.C.</u>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/13/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>				<b>23d. LOCATION (City, town or county)</b> <u>Washington D. C.</u>				<b>(State)</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons</u>				<b>ADDRESS</b> <u>Hyattsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 16 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>											

MEDICAL CERTIFICATION

3503

(M)

Phone George

1/2

Phone George's Street Highway

Phone

Phone

Telephone operator

Operator

(T)

Alfred Johnson

Home

1st only street

Telephone number

Telephone

Telephone

Telephone

William L. Jones, Louisville, Mo.

James Smith

March 2/12/81

Alfred C. Camery

Washington D. C.

James's sons, Louisville, Mo.

March 1/81

210 East St., N.W., Washington, D.C.

Mr. James C. Camery, N.W.

James C. Camery, N.W.

3-10-81

1-12-81

3-10-81

Phone George

Phone

Phone

Phone

Phone

Phone

7-19-81

Operator

U.S.

may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03498

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P.B.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>NYE</u> Last <u>Steiger</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/83</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Laurel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HARRY Steiger</u>		14. MOTHER'S MAIDEN NAME <u>NYE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>St. Marbury</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>434.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO <u>Compensated Ab. Failure</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from <u>1959</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred on <u>March 2, 1961</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Robert O. Maynard</u> M.D.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Laurel, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation March 2</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Selby</u>		25a. REC'D BY REGISTRAR <u>Mar 6 '61</u>	
ADDRESS <u>502 4th St Laurel Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>	

10810

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

3200

First Name: John  
Last Name: Jones  
Sex: Male  
Age: 72

Place of Birth: [illegible]

Occupation: [illegible]

Marital Status: [illegible]

Education: [illegible]

Religion: [illegible]

Usual Residence: [illegible]

Place of Death: [illegible]

Date of Death: [illegible]

Time of Death: [illegible]

Cause of Death: [illegible]

Immediate Cause: [illegible]

Underlying Cause: [illegible]

Contributing Cause: [illegible]

Medical History: [illegible]

History of Present Illness: [illegible]

Post-mortem Examination: [illegible]



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please state the date the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03499									
Items 9 & 14 Film 285 4/17/61									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN lb <b>30</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					d. STREET ADDRESS <b>6414 Jay Street N. E.</b>				
3. NAME OF DECEASED (Type or print) <b>Richard R. Stewart</b>					4. DATE OF DEATH <b>March 26th., 19 61</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Negro</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>July 6, 1875</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>					11. BIRTH PLACE (State or foreign country) <b>Maryland</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Frank Stewart</b>					14. MOTHER'S MAIDEN NAME <b>Eliza Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>Mary A. Stewart, same as # 2</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured hip, right 1950</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>March 27th., 1961</b>									
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D. EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b> Address (Street, city, town, or county)									
22a. BURIAL CREMATION, REMOVAL (Specify) <b>3-29-61</b>									
22b. DATE THEREOF									
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>									
22d. LOCATION (City, town, or county) (State) <b>Washington N.C.</b>									
23. FUNERAL DIRECTOR ADDRESS <b>H.S. Washington + Sons 4925 Denne Ave NE</b>									
24a. REC'D BY REGISTRAR DATE <b>APR 3 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>									

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may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3506 CERTIFICATE OF DEATH 03500

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2316--Que St., S. E.	
3. NAME OF DECEASED (Type or print) First Middle Last Jennie A. Stone		4. DATE OF DEATH Month Day Year March 1 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 2, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sipple		14. MOTHER'S MAIDEN NAME Eynon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Mary E. Ryon		Address 2316--Que St., SE Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (acute)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis (Senile)</u> (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr Osteoarthritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Natural Causes</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Suitland</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>61</u> to <u>March 1</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Feb 28</u> 19 <u>61</u> and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul C. Van Natta</u>		22b. DATE SIGNED 3/16/61	
22c. PHYSICIAN'S NAME (Type) Paul C. Van Natta		22d. ADDRESS 5440 Silver Hill Rd. Parkland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland, P.G. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simpson Bros</u>		25a. REC'D BY REGISTRAR DATE MAR 2 '61	
ADDRESS 1661--Good Hope Rd. SE Wash. 20 DC		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

05750

CERTIFICATE OF DEATH

3508

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3507  
CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brandywine - Waldorf Med Center		d. STREET ADDRESS 08X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Venola, G. Strang		4. DATE OF DEATH Month Day Year March 20 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30 1907
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY S.C.	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry German		14. MOTHER'S MAIDEN NAME Anna Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 249 01 7559	
17. INFORMANT Charles A. Strang (husband) White Plains, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial infarct (b) DUE TO Sudden Coronary Heart Attack (c) DUE TO Agg P PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-15 1961, to 3-20 1961, that (II) (we) last saw the deceased alive on 3-20 1961, and that death occurred at 7:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Richard Dobson M.D.		22b. ADDRESS Brandywine, Md.	
22d. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-24-61	
23c. NAME OF CEMETERY OR CREMATORY Langley Cemetery		23d. LOCATION (City, town, or county) (State) Langley, S.C.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Huntt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE MAR 24 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

3507

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JAN 10 1911



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FOR STATE  
HEALTH DEPT.  
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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3508 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03502									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <b>4817 - 14th. St., N.W.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>FRANK AUSTIN SWARTWOUT, Jr.</b>					4. DATE OF DEATH <b>March 6, 1961</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Caucasian</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					8. DATE OF BIRTH <b>August 20, 1904</b>				
9. AGE (in years last birthday) <b>56</b> yrs.					10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive-Chief, University of Md.</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>				
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frank Austin Swartwout</b>					14. MOTHER'S MAIDEN NAME <b>Bessie Slater</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>577-01-3498</b>				
17. INFORMANT <b>Dr. John A. Swartwout</b>					Address <b>#8 Stratford Rd. Melrose, Mass.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Liver Cirrhosis</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.									
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <b>March 6, 1961</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>3/8/1961</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>									
22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>									
23. FUNERAL DIRECTOR <b>S.H. HINES CO.</b>									
ADDRESS <b>2901 14th St., N.W. Wash. D.C.</b>									
24a. REC'D BY REGISTRAR <b>MAR 8 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									

61 011000 000111

Удостоверение

Private George J. Connelley

09-20-55

### Acute Congestive Heart Failure

Approved for Release by NSA on 08-25-2013 pursuant to E.O. 13526

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and the 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 1 & 2 Film 6284 4/7/61 1st											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville Md.</b> c. LENGTH OF STAY IN 1b <b>Md.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7620 Marlboro Pike</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville, Md.</b> d. STREET ADDRESS <b>7620 Marlboro Pike</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>C.</b> Last <b>THOMAS</b>						4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 Sept 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fraser</b>						14. MOTHER'S MAIDEN NAME <b>Georgia Anna Pumphrey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John E. Thomas (2d)</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>General Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>unknown</b> <b>unknown</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>natural causes</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1960</b> to <b>March 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 29, 1961</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Paul C Van Natta</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/29/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>PAUL C VAN NATTA</b>						22d. ADDRESS <b>5440 Silver Hill Rd SE DC 28.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1 April '61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 300 4th St. N.E. Wash.</b>						ADDRESS <b>DC</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

3803

Police George

West Maryland

White

Female

Post Office

John Fraser

No

Home

John E. Thomas (28)

George and Pugh

U.S. Government

U.S.A.

(1)

Oranston 1 April 1945

Lee Tunnel Home 300-4th St. S.E. Wash.

Washington

D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3510

03504

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>1 yr., 2 mos. &amp; 28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> <span style="float: right;">b. COUNTY <b>-</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1161 3rd St., N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Eugene</b> Middle <b>Sylvester</b> Last <b>Thomas</b>			<b>4. DATE OF DEATH</b> Month <b>3</b> Day <b>28</b> Year <b>19 61</b>				
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> <b>6. COLOR OR RACE</b> Negro <input checked="" type="checkbox"/> White <input type="checkbox"/>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/6/98</b> <b>9. AGE (In years last birthday)</b> <b>62 yrs.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>self employed</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			<b>13. FATHER'S NAME</b> <b>Alexander Thomas</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary ?</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War II</b>				
<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>			<b>17. INFORMANT</b> <b>Decedent</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Carcinoma of right colon with metastases</b> IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis, mod. advanced, active (1 yr. 4 mo.); rt. hemi-colectomy and end to end anastomosis 1/2/59.</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>12/30/1959</u> to <u>3/28/1961</u> that (I) (we) last saw the deceased alive on <u>3/28/1961</u>, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Moe Weiss</i>			<b>22b. DATE SIGNED</b> <b>3/28/61</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Moe Weiss, M. D.</b>			<b>22d. ADDRESS</b> <b>Glenn Dale Hospital Glenn Dale, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/3/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet</b>			
<b>23d. LOCATION (City, town or county) (State)</b> <b>Washington, D.C.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John I. Stewart</i>					
<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 3 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>C. E. K...</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1940

(M)

Washington

1 yr. 2 mos.

Glenn Dale (trial)

Glenn Dale Hospital

1940

Glenn Dale

Glenn Dale

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3511

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03505

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Toney		4. DATE OF DEATH Month Day Year March 25 19 61	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>Sp.</del> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 April 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jefferson D. Johnson, Sr.		14. MOTHER'S MAIDEN NAME Edith A. Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT Decedent		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199X Abdominal Carcinomatosis DUE TO (b) Primary unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>                    </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) (County) (State) <u>                    </u>	
21. I certify that (I) (this hospital) attended the deceased from Mar. 3 19 61 to Mar. 25 19 61, that (I) (we) last saw the deceased alive on Mar. 25 19 61, and that death occurred 10:30 PM from the causes and on the date stated above.		22a. SIGNATURE Harry N. Carlton, M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE 3 27 61 SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Harry N. Carlton. M.D.		22d. ADDRESS 940 25th St. Washington, D.C.	
23a. BURIAL CREMATION, REMOVAL (Specify) 3-29-61		23b. DATE THEREOF 3-29-61	
23c. NAME OF CEMETERY OR CREMATORY National Harmony		23d. LOCATION (City, town, or county) (State) Highland Park Md	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons 4925 Deane Ave		25a. REC'D BY REGISTRAR APR 3 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MINISTRE DU SÉCRÉTARIAT GÉNÉRAL  
DE LA SANTÉ  
CERTIFICATE OF DEATH

3511

03511

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3512

CERTIFICATE OF DEATH

Reg. Dist. No.

03506

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home.		d. STREET ADDRESS 5407 Silver Hill Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Lakin Last Waesche		4. DATE OF DEATH Month March Day 12th Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1876
9. AGE (In years day birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maine
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Carydon Lakin		14. MOTHER'S MAIDEN NAME Georgianna Clarke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Address John L. Waesche 5407 Silver Hill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO BRONCHOPNEUMONIA - Acute Severe (b) Acute Cerebrovascular Accident 12 DAYS (c) Hypertensive arteriosclerosis 10-12 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1953 to MARCH 12, 1961, that I last saw the deceased alive on MARCH 11, 1961, and that death occurred at 10:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney W. Lowry M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY M.D.		P. ADDRESS (Street, city or town, state) 7300 MARLBORO PIKE SE.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 15 Mar. 1961	22c. NAME OF CEMETERY OR CREMATORY Monocacy Cem.	22d. LOCATION (City, town, or county) Beallsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E.		24a. REC'D BY REGISTRAR MAR 14 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

CERTIFICATE OF DEATH

1912

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

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2

3

4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3513

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>2-3 hr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Island Memorial Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park, Md</i>	
d. STREET ADDRESS <i>18510 Tolomae Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARGARET</i> Middle <i>WERBER</i> Last <i>WERBER</i>		4. DATE OF DEATH <i>MAR 21</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 8, 1880</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Pr Geo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Wm Lepton</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Martini</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>W M WERTBER</i> Address <i>Hyattsville, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Arterio-sclerotic Heart Dis.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>February 18, 1961</i> to <i>March 6, 1961</i> , that (I) (we) last saw the deceased alive on <i>February 24, 1961</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W. C. Etienne</i>		22b. ADDRESS <i>471 1/2 Perry St Calverton, Md</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		22d. ADDRESS <i>471 1/2 Perry St Calverton, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3/24/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 23 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

076

103507

3213

11/20/1910  
BOSTON  
MAYOR  
CITY OF BOSTON  
BUREAU OF VITAL RECORDS  
BIRTH CERTIFICATE  
No. 3213  
Date of Birth  
Place of Birth  
Sex  
Color  
Religion  
Name of Father  
Name of Mother  
Name of Child  
Signature of Registrar  
Signature of Parent  
Signature of Child



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3514 CERTIFICATE OF DEATH 03508											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT					
c. LENGTH OF STAY IN 1b 40 yrs.						d. STREET ADDRESS 7115- "F" STREET					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7115- "F" STREET						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) OLIVIA CASE						4. DATE OF DEATH 3 9 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/1867		9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk- U.S. Gov't. -- Treas. Dept.						11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Elizabeth Case						14. MOTHER'S MAIDEN NAME Eunice E. Ballard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) no						16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Grace E. Franck -- Richlands, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO (b) Hypertensive-Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 3/11/1961 Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3/11/1961 to 3/16/1961, that (I) (we) last saw the deceased alive on 3/6/1961, and that death occurred at 2:45 P.M. from the causes and on the date stated above. 22a. SIGNATURE Max M. Herzberg M.D. 22b. DATE SIGNED 3-9-61 22c. PHYSICIAN'S NAME (Type) Max M. Herzberg 22d. ADDRESS 7016 GREIG ST, SEAT PLEASANT, MD 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 3/11/61 23c. NAME OF CEMETERY OR CREMATORY Whitaker Cemetery 23d. LOCATION (City, town or county) (State) Mills River, North Carolina 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S.H. Hines Co. - 2901 14th St., N.W. Washington 9, D.C. 25a. REC'D BY REGISTRAR DATE MAR 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Krame											

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1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03509											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fargo</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fargo</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 2640 Upper Marlboro</u>						d. STREET ADDRESS <u>Box 2640 Upper Marlboro</u>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth E. Monaghan Williams</u>						4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 7, 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Thomas</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Henry Thomas, same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interlobular osteomyelitis</u> 012.3											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>NAMES I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-18-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>3/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) <u>Suitland, Md</u> (State)	
23. FUNERAL DIRECTOR <u>A. J. Haffell</u>						ADDRESS <u>47-5-H-NY</u>		24a. REC'D BY REGISTRAR <u>MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

WILLIAM AND I HAVE BEEN MARRIED  
SINCE 1901. I HAVE BEEN A MEMBER OF THE  
UNITED STATES ARMY SINCE 1901. I HAVE BEEN  
A MEMBER OF THE UNITED STATES ARMY SINCE 1901.  
I HAVE BEEN A MEMBER OF THE UNITED STATES ARMY SINCE 1901.

UNITED STATES ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

(M)

(1)

UNITED STATES ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

UNITED STATES ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

## CERTIFICATE OF DEATH

Reg. Dist. No.

03511

3516

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN lb 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4102-33rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. B. Middle Tofford Last		4. DATE OF DEATH Month March Day 14 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Census Bureau		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Crystal City Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Tofford		14. MOTHER'S MAIDEN NAME Martha A. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-48-7139	
17. INFORMANT Mary A. Hyvill		Address Upper Marlboro Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) City supervisor			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18, 1961, to 3/19, 1961, that I last saw the deceased alive on 3/18, 1961, and that death occurred at 1 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED 3/19/61	
PHYSICIAN'S NAME (Type) A K BOWIE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/61	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR ADDRESS Mt. Rainier Md. DATE MAR 22 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

2316

(M)

(1)

*[Faint, illegible handwritten text, possibly a signature]*

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten mark]*



**1**  
**FOR STATE**  
**HEALTH DEPT.**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G284 4/4/61 iwk

03512

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Southland</u>		c. LENGTH OF STAY IN <u>5 months</u> <u>29</u> <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southland Nursing Home</u>		d. STREET ADDRESS <u>1200-69th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Euclavia Woodend</u> First Middle Last		4. DATE OF DEATH <u>March 24 1961</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 1879</u> 1879
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. B. Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Kate E. Willett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Ethel L. Limerick, same as #2</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>442X</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardiovascular renal disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fractured right hip 6-30-59</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-24-61</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, OR DISPOSITION <u>Buried</u>	22b. DATE THEREOF <u>3/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR <u>J. Wm. Lee's Sons Co. 300-4th St. N.E.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 27 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

RECEIVED BY THE DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C. 20315  
1951

THE ADJUTANT  
GENERAL  
WASHINGTON, D.C. 20315



RECEIVED BY THE DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C. 20315  
1951

OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C. 20315  
1951

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3518

## CERTIFICATE OF DEATH

Reg. Dist. No. 3513

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarman Hight</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Jarman Hight</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK C. YOUNG</u>				4. DATE OF DEATH Month Day Year <u>MARCH 18 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1 1891</u>	9. AGE (In years last birthday) yrs. <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH E. YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>Georgina Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1262 YOUNG - Daughter</u>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROSIS</u> <u>444x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 7 -</u> , 19 <u>60</u> , to <u>MARCH 18</u> , 19 <u>61</u> that I last saw the deceased alive on <u>MARCH 18</u> , 19 <u>61</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. Beldan</u> M.D. <u>4423 - HUNT PL. NE</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H. C. Beldan M.D.</u> <u>Wash - 19 - DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>1870 - 9 St Wash. DC.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any way is necessary, please call the State Health Department, 301 W. Preston Street, Baltimore 1, Maryland, for the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 3519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03514

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> c. LENGTH OF STAY IN 1b <u>27</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Maryland Park</u> d. STREET ADDRESS <u>211-6 5th Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Werner John Zimmerli</u>		4. DATE OF DEATH <u>March 26 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 8, 1901</u>		9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>37</u> Min.		11. IF UNDER 24 HRS. Hours <u>37</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Skilled</u>				11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Edward Zimmerli</u>				14. MOTHER'S MAIDEN NAME <u>Emily Mary Slarnik</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-34-123456</u>				17. INFORMANT <u>Mrs W J Zimmerli, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, bilateral hydrothorax</u> <u>450.0</u> DUE TO (b) <u>saddle thrombus of aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerosis of aorta</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-27-61</u>							
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				Address (Street, city, town, or county) <u>Washington, D.C.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				23. REC'D BY REGISTRAR <u>W. W. Chambers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-29-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem</u>				22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR <u>W. W. Chambers</u>				ADDRESS <u>301 W. Preston Street</u>				24. REC'D BY REGISTRAR <u>W. W. Chambers</u>				25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

THE  
MAY 2 1911



Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 1st inst. in relation to the matter of the